

# 2019

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Volume 2

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## Dental Education, Science and Related Matters

Resolution No. 17-25 NewReport: Board Report 5 Date Submitted: June 2019Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None

Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_

Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

## REPORT 5 OF THE BOARD OF TRUSTEES: GOVERNANCE CHANGES FOR ADA COMMISSIONS

**Action Requested:** The House of Delegates is requested to consider resolutions proposing governance changes to the ADA *Bylaws* and the ADA *Governance and Organizational Manual* as presented. These changes are intended to align the governance of the Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition and the National Commission on Recognition of Dental Specialties and Certifying Boards with the governance changes approved by the House last year relating to the Commission on Dental Accreditation.

**Background:** There are four commissions housed within the ADA governance structure: The Commission on Dental Accreditation (CODA), the Joint Commission on National Dental Examinations (JCNDE), the Commission on Continuing Education Provider Recognition (CCEPR), and the National Commission on Recognition of Dental Specialties and Certifying Boards (NCRDSCB). Each of the commissions is a semi-autonomous agency of the ADA with authority to administer a specific program as outlined in the ADA *Bylaws*. The commission programs (accreditation, licensure examinations, continuing education provider recognition, and dental specialty recognition) involve a public trust that require the programs be administered, and decisions be made, in a consistent manner that is free from bias and conflict of interest. Through the promulgation of quality standards and criteria, the commissions endeavor to protect the public, students, and the profession with integrity, confidentiality protections, and due process. This also assures the long-term viability of the profession as a self-regulating profession.

Commissions must have mechanisms in place to guard against any particular community of interest, including the ADA, having an undue influence on commission decisions and program administration. The mechanisms that safeguard the ADA commissions from this conflict of interest include the delegation of certain governance rights and procedures to the commissions within the ADA *Bylaws*, the ADA *Governance and Organizational Manual*, and the ADA *Standing Rules for Councils and Commissions*.

The ADA commissions were each established at different points in time over the past forty-four years. The governance structures of the four ADA commissions are not consistent and each is a reflection of the understanding of best practices for governance and controlling for conflict of interest at the time each commission was formed. In other words, while the expectations of the public and government entities on controlling for conflict has evolved over time, the governance structure of the commissions housed within the ADA have not, until last year, changed appreciably to reflect the contemporary best practices. This has led to a perception amongst some communities of interest, including the public, that the ADA has an undue influence on commission decisions.

The ADA-CODA Relationship Workgroup, consisting of appointees from the Board of Trustees and CODA, spent considerable time discussing these issues relating to the governance of CODA. In 2018, the Workgroup made recommendations to revise the *ADA Bylaws, Governance and Organizational Manual*, and *Standing Rules for Councils and Commissions* to not only address the conflict of interest perception, but also to align CODA governance with the best practices for controlling for conflict of interest, as outlined in the USDE criteria for recognized accreditors. Subsequently, the 2018 ADA House of Delegates adopted the recommended revisions to the *ADA Bylaws* and *Governance Manual*, and the Board of Trustees adopted the recommended revisions to the *Standing Rules for Councils and Commissions*. Because the rationale for forming a commission (as outlined above) does not vary by the administration of a specific program, differences in governance between commissions can lead to misunderstandings and confusion about the role of each commission by the public, the profession, and ADA members. So too does disparate governance practices among the four commissions add to needless complexity within the Association's governance structure and unnecessary time demands on the ADA staff. The changes proposed in this report will now align the remaining three ADA commissions with the governance changes already approved by the House with respect to CODA. The JCNDE, CCEPR and NCRDSCB have endorsed the proposed governance changes as presented.

The proposed *Bylaws* changes for the JCNDE and CCEPR standardize the outline of Section 30. Duties, to the following for all commissions: a statement of the specific program to be administered; authority to develop standards and/or guidelines for administration of the program; authority to establish an appeals process for adverse commission decisions; a requirement to submit an annual report to the House of Delegates (with the exception of CODA); and a requirement to submit an annual budget to the Board of Trustees. In addition, the Board of Trustees is suggesting revisions to the *Bylaws* for the JCNDE allowing it flexibility to administer licensure examinations to other members of the oral health care team besides dentists and dental hygienists, and to allow it to develop certification exams.

The *Bylaws* changes require a two-thirds vote of the House of Delegates.

The proposed *Governance Manual* changes include: granting the commissions sole authority to remove a commissioner for cause; granting a commission chair the sole authority to declare a position vacant when a commission member ceases to be a member of the selecting organization; granting the commissions authority to appoint consultants to assist in the administration of their respective programs; granting the commissions authority to conduct meetings in accordance with their *Rules*; granting the commissions the authority to define a quorum for meetings; and granting the commissions the authority to adopt their own rules. As noted earlier in this report, these proposed changes were adopted by the House of Delegates for CODA last year and were identified as real or perceived conflict of interest issues. The *Governance Manual* revision related to nomination and selection of ADA, ADEA and AADB members is a clarification, simplification, and standardization of language that applies to all commissions, including CODA. This includes a revision for direct appointment of ADA members by the Board of Trustees, to align CODA, JCNDE, and CCEPR with the NCRDSCB.

The *Governance Manual* changes require a majority vote of the House of Delegates.

The Board proposes the following resolutions for the House's consideration.

#### **Proposed Bylaws Resolutions**

**17. Resolved**, that the *ADA Bylaws*, Section 30. Duties, Subsection B. Joint Commission on National Dental Examinations, be amended as follows (new language underscored, deletions ~~stricken~~):

B. JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS. The duties of the Joint Commission on National Dental Examinations shall be to:

- a. Provide and conduct ~~written~~ examinations, ~~exclusive of clinical demonstrations~~ for the purpose of ~~assisting state boards of dental examiners in~~ determining qualifications of oral health care professionals ~~dentists who seeking certification~~

and/or licensure to practice in any state or other jurisdiction of the United States. ~~Dental licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.~~

- b. ~~Make rules and regulations for the conduct of examinations and the certification of successful candidates. Provide and conduct written examinations, exclusive of clinical demonstrations for the purpose of assisting state boards of dental examiners in determining qualifications of dental hygienists who seek license to practice in any state or other jurisdiction of the United States. Dental hygiene licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.~~
- c. ~~Serve as a resource of for oral health care professionals the dental profession in concerning the development of written examinations. Make rules and regulations for the conduct of examinations and the certification of successful candidates.~~
- d. ~~Provide a means for a candidate to appeal an adverse decision of the Commission. Serve as a resource of the dental profession in the development of written examinations.~~
- e. Submit an annual report to the House of Delegates of this Association and interim reports, on request.
- f. Submit an annual budget to the Board of Trustees of the Association.

**18. Resolved**, that the ADA *Bylaws*, Section 30. Duties, Subsection C. Commission on Continuing Education Provider Recognition be amended as follows (new language underscored, deletions ~~stricken~~):

- C. COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION. The duties of the Commission for Continuing Education Provider Recognition shall be to:
  - a. Formulate and adopt requirements, guidelines and procedures for the recognition of continuing dental education providers.
  - b. Approve providers of continuing dental education programs and activities.
  - c. Provide a means for continuing dental education providers to appeal adverse recognition decisions.
  - d. ~~Submit an annual report to the House of Delegates of this Association and interim reports, on request, and the Commission's annual budget to the Board of Trustees of the Association.~~
  - e. Submit an annual budget to the Board of Trustees of the Association. Submit the Commission's rules and amendments thereto to this Association's House of Delegates for approval by majority vote either through or in cooperation with the Council on Dental Education and Licensure.

### **Proposed Governance Manual Resolutions**

**19. Resolved**, that the ADA *Governance Manual*, Chapter IX. Commissions, Section A. Members, Selections, Nominations and Elections be amended to common language across all commissions for nomination and selection of ADA, ADEA and AADB members as follows (new language underscored, deletions ~~stricken~~):

- A. Members, Selections, Nominations and Elections.
  1. Commission on Dental Accreditation. The number of and the method of selection of members of the Commission on Dental Accreditation shall be governed by the *Rules of the Commission on Dental Accreditation*, except that twelve ~~Twelve~~ (12)

of the members of the Commission on Dental Accreditation shall be selected as follows:

- a. ~~Four (4) members shall be selected from nominations of active, life or retired members of this Association, with the nominations open to all trustee districts. None of the nominees shall be a faculty member working for a school of dentistry more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency. These members shall be nominated by the Board of Trustees and elected by the House of Delegates. Four (4) members who shall be appointed by the Board of Trustees from the names of active, life or retired members of this Association. None of the appointees shall be a faculty member working for a school of dentistry more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency.~~
- b. Four (4) members who are active, life or retired members of this Association and also active members of the American Association of Dental Boards shall be selected by the American Association of Dental Boards. None of these members shall be a member of a faculty of a school of dentistry.
- c. Four (4) members who are active, life or retired members of this Association and also active members of the American Dental Education Association shall be selected by the American Association of Dental BoardsAmerican Dental Education Association. None of these members shall be a member of any state board of dental examiners or jurisdictional dental licensing agency.

2. Joint Commission on National Dental Examinations. The number of and the method of selection of members of the Joint Commission on National Dental Examinations shall be governed by the Rules of the Joint Commission on National Dental Examinations, except that twelve (12) members shall be selected as follows: The Joint Commission on National Dental Examinations shall be composed of fifteen (15) members selected as follows:

- a. ~~Three (3) members shall be nominated by the Board of Trustees from the active, life or retired members of this Association. Additional nominations of active, life or retired members may be made by the House of Delegates. None of the ADA nominees shall be a member of a faculty of a school of dentistry or a member of a state board of dental examiners or jurisdictional dental licensing agency. The House of Delegates shall elect the three (3) members from those nominated by the Board of Trustees and the House of Delegates.~~  
Three (3) members who shall be appointed by the Board of Trustees from the names of active, life or retired members of this Association. None of the appointees shall be a faculty member working for a school of dentistry more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency.
- b. Six (6) members who are active, life or retired members of this Association and also active members of the American Association of Dental Boards shall be selected by the American Association of Dental Boards. None of these members shall be a member of a faculty of a school of dentistry.
- c. Three (3) members who are active, life or retired members of this Association and also active members of the American Dental Education Association shall be selected by the American Dental Education Association. None of these members shall be a member of any state board of dental examiners or jurisdictional dental licensing agency.
- d. ~~One (1) member who is a dental hygienist shall be selected by the American Dental Hygienists' Association.~~

- 1 ~~e. One (1) member who is a public representative shall be selected by the Joint~~  
2 ~~Commission on National Dental Examinations.~~  
3 ~~f. One (1) member who is a dental student shall be selected annually by the~~  
4 ~~American Student Dental Association.~~  
5  
6 3. Commission for Continuing Education Provider Recognition. The number of and  
7 the method of selection of members of the Commission for Continuing Education  
8 Provider Recognition shall be governed by the *Rules of the Commission for*  
9 *Continuing Education Provider Recognition*, except that six (6) members shall be  
10 selected as follows: The Commission for Continuing Education Provider  
11 Recognition shall be composed of sixteen (16) members selected as follows:  
12 a. Four (4) members who shall be appointed by the Board of Trustees from the  
13 names of active, life or retired members of this Association. None of the  
14 appointees shall be a faculty member working for a school of dentistry more  
15 than one day per week or a member of a state board of dental examiners or  
16 jurisdictional dental licensing agency. ~~Four (4) members shall be selected~~  
17 ~~from nominations of active, life or retired members of this Association, with the~~  
18 ~~nominations open to all trustee districts. At least two (2) of the members~~  
19 ~~nominated appointed shall be general dentists, who shall be selected from~~  
20 ~~nominations open to all trustee districts from the active, life or retired~~  
21 ~~members of the Association. These members shall be nominated by the~~  
22 ~~Board of Trustees and elected by the House of Delegates.~~  
23 b. One (1) member who is an active member of the American Association of  
24 Dental Boards and also, if eligible, an active, life or retired member of this  
25 Association shall be selected by the American Association of Dental Boards.  
26 c. One (1) member who is an active member of the American Dental Education  
27 Association and also, if eligible, an active, life or retired member of this  
28 Association shall be selected by the American Dental Education Association.  
29 ~~d. One (1) member who is an active member of the American Society of~~  
30 ~~Constituent Dental Executives and also, if eligible, an active, life or retired~~  
31 ~~member of this Association shall be selected by the American Society of~~  
32 ~~Constituent Dental Executives.~~  
33 ~~e. One (1) member who is an active, life or retired member of this Association~~  
34 ~~shall be selected by the sponsoring organization of each ADA dental specialty~~  
35 ~~recognized by the ADA.<sup>2</sup>~~  
36  
37 4. National Commission on Recognition of Dental Specialties and Certifying Boards.  
38 The National Commission on Recognition of Dental Specialties and Certifying  
39 Boards shall be composed of members selected as follows:  
40 a. One (1) specialist from each dental specialty recognized by this Association or  
41 Commission who is an active, life or retired member of this Association  
42 appointed by the sponsoring organization for that specialty.  
43 b. A number of general dentists equal to the number of members appointed  
44 pursuant to subsection 4.a. of this Section who are active, life or retired  
45 members of this Association appointed by the Board of Trustees.  
46 c. A member of the general public appointed by the Commission.\*  
47 5. Amendment. The entirety of this Section A of Chapter IX is amendable by a two-  
48 thirds (2/3) affirmative vote of delegates present and voting provided that the

\* To achieve the desired staggering of member terms for continuity, the initial terms of the members of the National Commission on Recognition of Dental Specialties and Certifying Boards shall be as set forth in Appendix 2 that accompanied Resolution 30H-2017 that established this Commission. This footnote shall expire without further action at the adjournment sine die of the 2021 House of Delegates.

proposed amendment(s) shall have been presented in writing at a previous session or a previous meeting of the same session of the House of Delegates.

**20. Resolved**, that ADA *Governance Manual*, Chapter IX. Commissions, Section B. Removal for Cause be amended to grant the commissions sole authority to remove a commissioner for cause as follows (new language underscored, deletions ~~stricken~~):

B. Removal for Cause.

1. ~~Any of the The Commission-commissions of this Association on Dental Accreditation shall have the sole authority to remove a Commission on Dental Accreditation any of its members for cause pursuant to the its Rules~~Rules of the Commission on Dental Accreditation, with notice of such removal being given.  
The Commission on Dental Accreditation shall provide notice to the ADA Board of Trustees once the Commission acts to remove a member for cause.
2. ~~The Board of Trustees may remove a member of the Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission for Recognition of Dental Specialties and Certifying Boards for cause in accordance with procedures established by the Board of Trustees, which procedures shall provide for notice of the charges, including allegations of the conduct purported to constitute each violation, and a decision in writing which shall specify the findings of fact which substantiate any and all of the charges. Prior to issuance of the decision of the Board of Trustees, no commission member shall be excused from attending any meeting of a commission unless there is an opportunity to be heard or compelling reasons exist which are specified in writing by the Board of Trustees.~~

**21. Resolved**, that the ADA *Governance Manual*, Chapter IX. Commissions, Section C. Eligibility be amended to grant a commission chair the sole authority to declare a position vacant when a commission member ceases to be a member of the selecting organization as follows (new language underscored, deletions ~~stricken~~):

C. Eligibility.

1. All members of commissions who are dentists must be active, life or retired members in good standing of this Association if eligible, except as otherwise provided in the *Bylaws*.
2. ~~A member of the Joint Commission on National Dental Examinations selected by the American Association of Dental Boards who ceases to be an active member of that organization may continue as a member of the Joint Commission on National Dental Examinations for the balance of that member's term.~~
3. ~~If a commission member of one of the Joint Commission on National Dental Examinations selected by the American Dental Education Association ceases to be a member of the organization that selected or elected the commission member, that commission member's faculty of a member school of that organization, the membership on the commission Joint Commission on National Dental Examinations shall terminate, and the President of this Association Chair of the commission shall declare the position vacant.~~
- 3.4. Any organizations that select members to serve on the Commission for Continuing Education Provider Recognition and offer continuing dental education courses must be recognized as a continuing education provider by the commission.
- 4.5. ~~No member of a commission may serve concurrently as a member of a council or another commission.~~

~~5.6.~~ A member shall not be eligible for appointment to another commission or council for a period of two (2) years after completing a previous commission or council appointment.

**22. Resolved**, that the ADA *Governance Manual*, Chapter IX. Commissions, Section E. Consultants, Advisors, and Staff be amended to grant the commissions authority to appoint consultants to assist in the administration of their respective programs as follows (new language underscoring, deletions ~~stricken~~):

E. Consultants, Advisers and Staff.

1. Consultants and Advisers.

- a. The Commission on Dental Accreditation shall have the power to appoint consultants to assist in developing requirements and guidelines for conducting the accreditation program and accreditation evaluations, including site visitations, of predoctoral, advanced ~~dental education~~, and allied dental education programs.
- b. ~~The Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission on Recognition of Dental Specialties and Certifying Boards shall have the authority to nominate consultants and advisers in conformity with rules and regulations established by the Board of Trustees except as otherwise provided in the Bylaws or this Governance Manual.~~ The Joint Commission on National Dental Examinations also shall have the power to appoint select consultants to serve on the commission's test construction teams committees and to assist with test administration, test development, test security and test psychometric evaluation.
- c. The Commission for Continuing Education Provider Recognition shall have the power to appoint consultants to assist in developing standards and procedures, conducting recognition reviews and conducting appeals.
- d. The National Commission on Recognition of Dental Specialties and Certifying Boards shall have the power to appoint consultants to assist in the periodic review of dental specialties, the annual review of dental specialty certifying boards, and in conducting appeals.

2. Staff. The Executive Director shall employ the staff of commissions, in the event they are employees, and shall select the titles for commission staff positions.

**23. Resolved**, that the ADA *Governance Manual*, Chapter IX. Commissions, Section H. Meetings of Commissions be amended to grant the commissions authority to conduct meetings in accordance with their *Rules* as follows (new language underscoring, deletions ~~stricken~~):

H. Meetings of Commissions. ~~Each commissions shall conduct meetings in accordance with its Rules. Commissions~~ The Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission on Recognition of Dental Specialties and Certifying Boards shall hold at least one regular meeting annually, provided that funds are available in the budget for that purpose or unless otherwise directed by the Board of Trustees. Meetings may be held at the ADA Headquarters Building, the ADA Washington Office or from multiple remote locations through the use of a conference telephone or other communications equipment by means of which all members can communicate with each other. Such meetings shall be conducted in accordance with rules and procedures established by the Board of Trustees. ~~The Commission on Dental Accreditation shall conduct~~

meetings in accordance with rules and procedures pursuant to the *Rules of the Commission on Dental Accreditation*.

**24. Resolved**, that the ADA *Governance Manual* Chapter IX. Commissions, Section I. Quorum be amended to grant the commissions the authority to define a quorum for meetings as follows (new language underscored, deletions ~~stricken~~):

I. Quorum. ~~A majority of the members of the Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission on Recognition of Dental Specialties and Certifying Boards shall constitute a quorum.~~ Quorum requirements for each the Commissions on Dental Accreditation shall be as stated in the *Rules of the Commission on Dental Accreditation* of that commission.

**25. Resolved**, that the ADA *Governance Manual* Chapter IX. Commissions, Section L. Power to Adopt Rules be amended to grant the commissions the authority to adopt rules as follows (new language underscored, deletions ~~stricken~~):

L. Power to Adopt Rules. Any commission of this Association shall have the power to adopt rules for such commission and amendments thereto, provided such rules and amendments thereto do not conflict with or limit the *Constitution and Bylaws, Governance and Organizational Manual and Standing Rules for Councils and Commissions* of this Association. ~~Rules and amendments thereto, adopted by the Joint Commission on National Dental Examinations and Commission for Continuing Education Provider Recognition, shall not be effective until submitted in writing to and approved by majority vote of the House of Delegates of this Association, except the Joint Commission on National Dental Examinations shall have such bylaws and amendments thereto as the House of Delegates of this Association may adopt by majority vote for the conduct of the purposes and management of the Joint Commission on National Dental Examinations. The Commission on Dental Accreditation and the National Commission on Recognition of Dental Specialties and Certifying Boards~~ Commissions shall have the power to adopt rules and amendments thereto pursuant to a two-thirds affirmative vote of the members present and voting. ~~The Commission for Continuing Education Provider Recognition shall have the authority to make corrections in punctuation, grammar, spelling, name changes, gender references, and similar editorial corrections to their Rules which do not alter context or meaning without the need to submit such editorial corrections to the House of Delegates. Such corrections shall be made only by a unanimous vote of the commission adopting such editorial correction.~~

(Res. 17; See Worksheet:4008)

(Res. 18; See Worksheet:4010)

(Res. 19; See Worksheet:4012)

(Res. 20; See Worksheet:4015)

(Res. 21; See Worksheet:4016)

(Res. 22; See Worksheet:4018)

(Res. 23; See Worksheet:4020)

(Res. 24; See Worksheet:4021)

(Res. 25; See Worksheet:4022)

**BOARD RECOMMENDATION: Vote Yes to Transmit.**

**BOARD VOTE: UNANIMOUS**

Resolution No. 17 NewReport: Board Report 5 Date Submitted: June 2019Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

**ADA BYLAWS AMENDMENTS FOR THE JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS****Background:** (See Report 5 of the Board of Trustees to the House of Delegates)**Resolution****17. Resolved**, that the ADA *Bylaws*, Section 30. Duties, Subsection B. Joint Commission on National Dental Examinations, be amended as follows (new language underscored, deletions ~~stricken~~):

B. JOINT COMMISSION ON NATIONAL DENTAL EXAMINATIONS. The duties of the Joint Commission on National Dental Examinations shall be to:

- a. Provide and conduct ~~written examinations, exclusive of clinical demonstrations~~ for the purpose of assisting state boards of dental examiners in determining qualifications of oral health care professionals ~~dentists who seeking certification and/or licensure~~ to practice in any state or other jurisdiction of the United States. ~~Dental licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.~~
- b. Make rules and regulations for the conduct of examinations and the certification of successful candidates. ~~Provide and conduct written examinations, exclusive of clinical demonstrations for the purpose of assisting state boards of dental examiners in determining qualifications of dental hygienists who seek license to practice in any state or other jurisdiction of the United States. Dental hygiene licensure is subject to the laws of the state or other jurisdiction of the United States and the conduct of all clinical examinations for licensure is reserved to the individual board of dental examiners.~~
- c. Serve as a resource ~~of~~ for oral health care professionals the dental profession in concerning the development of ~~written examinations. Make rules and regulations for the conduct of examinations and the certification of successful candidates.~~
- d. Provide a means for a candidate to appeal an adverse decision of the Commission. Serve as a resource of the dental profession in the development of written examinations.
- e. Submit an annual report to the House of Delegates of this Association and interim reports, on request.
- f. Submit an annual budget to the Board of Trustees of the Association.

**1 BOARD RECOMMENDATION: Vote Yes.****2 Vote: Resolution 17**

BLACK	Yes	GEHANI	No	KLEMMEDSON	Yes	RODRIGUEZ	Yes
COHLMIA	Yes	HARRINGTON	Yes	KYGER	Yes	SABATES	No
DOROSHOW	Yes	HERRE	Yes	LEARY	Yes	SHEPLEY	Yes
EDGAR	Yes	HIMMELBERGER	Yes	MCDUGALL	Yes	STEPHENS	Yes
FISCH	Yes	HUOT	Yes	NORBO	Yes	THOMPSON	Yes

**3**

Resolution No. 18 NewReport: Board Report 5 Date Submitted: June 2019Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None

Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_

Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

**ADA BYLAWS AMENDMENTS FOR THE COMMISSION ON CONTINUING EDUCATION PROVIDER RECOGNITION****Background:** (See Report 5 of the Board of Trustees to the House of Delegates)**Resolution**

**18. Resolved,** that the ADA *Bylaws*, Section 30. Duties, Subsection C. Commission on Continuing Education Provider Recognition be amended as follows (new language underscored, deletions ~~stricken~~):

- C. COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION. The duties of the Commission for Continuing Education Provider Recognition shall be to:
- a. Formulate and adopt requirements, guidelines and procedures for the recognition of continuing dental education providers.
  - b. Approve providers of continuing dental education programs and activities.
  - c. Provide a means for continuing dental education providers to appeal adverse recognition decisions.
  - d. Submit an annual report to the House of Delegates of this Association and interim reports, on request, ~~and the Commission's annual budget to the Board of Trustees of the Association.~~
  - e. Submit an annual budget to the Board of Trustees of the Association. Submit the Commission's rules and amendments thereto to this Association's House of Delegates for approval by majority vote either through or in cooperation with the Council on Dental Education and Licensure.

**1 BOARD RECOMMENDATION: Vote Yes.****2 Vote: Resolution 18**

BLACK	Yes	GEHANI	Yes	KLEMMEDSON	Yes	RODRIGUEZ	Yes
COHLMIA	Yes	HARRINGTON	Yes	KYGER	Yes	SABATES	No
DOROSHOW	Yes	HERRE	Yes	LEARY	Yes	SHEPLEY	Yes
EDGAR	Yes	HIMMELBERGER	Yes	MCDUGALL	Yes	STEPHENS	Yes
FISCH	Yes	HUOT	Yes	NORBO	Yes	THOMPSON	Yes

**3**

Resolution No. 19 NewReport: Board Report 5 Date Submitted: June 2019Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None

Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_

Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

## AMENDMENTS TO CHAPTER IX, SECTION A OF THE ADA GOVERNANCE MANUAL

**Background:** (See Report 5 of the Board of Trustees to the House of Delegates)

### Resolution

**19. Resolved,** that the *ADA Governance Manual*, Chapter IX. Commissions, Section A. Members, Selections, Nominations and Elections be amended to common language across all commissions for nomination and selection of ADA, ADEA and AADB members as follows (new language underscored, deletions ~~stricken~~):

#### A. Members, Selections, Nominations and Elections.

1. Commission on Dental Accreditation. The number of and the method of selection of members of the Commission on Dental Accreditation shall be governed by the *Rules of the Commission on Dental Accreditation*, ~~except that twelve~~ Twelve (12) ~~of the members of the Commission on Dental Accreditation shall be selected as follows:~~
  - a. ~~Four (4) members shall be selected from nominations of active, life or retired members of this Association, with the nominations open to all trustee districts. None of the nominees shall be a faculty member working for a school of dentistry more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency. These members shall be nominated by the Board of Trustees and elected by the House of Delegates. Four (4) members who shall be appointed by the Board of Trustees from the names of active, life or retired members of this Association. None of the appointees shall be a faculty member working for a school of dentistry more than one day per week or a member of a state board of dental examiners or jurisdictional dental licensing agency.~~
  - b. Four (4) members who are active, life or retired members of this Association and also active members of the American Association of Dental Boards shall be selected by the American Association of Dental Boards. None of these members shall be a member of a faculty of a school of dentistry.
  - c. Four (4) members who are active, life or retired members of this Association and also active members of the American Dental Education Association shall be selected by the ~~American Association of Dental Boards~~ American Dental

- 1                    Education Association. None of these members shall be a member of any  
2                    state board of dental examiners or jurisdictional dental licensing agency.  
3
- 4                    2. Joint Commission on National Dental Examinations. The number of and the  
5                    method of selection of members of the Joint Commission on National Dental  
6                    Examinations shall be governed by the Rules of the Joint Commission on National  
7                    Dental Examinations, except that twelve (12) members shall be selected as  
8                    follows: ~~The Joint Commission on National Dental Examinations shall be~~  
9                    ~~composed of fifteen (15) members selected as follows:~~
- 10                  a. ~~Three (3) members shall be nominated by the Board of Trustees from the~~  
11                  ~~active, life or retired members of this Association. Additional nominations of~~  
12                  ~~active, life or retired members may be made by the House of Delegates.~~  
13                  ~~None of the ADA nominees shall be a member of a faculty of a school of~~  
14                  ~~dentistry or a member of a state board of dental examiners or jurisdictional~~  
15                  ~~dental licensing agency. The House of Delegates shall elect the three (3)~~  
16                  ~~members from those nominated by the Board of Trustees and the House of~~  
17                  ~~Delegates.~~  
18                  Three (3) members who shall be appointed by the Board of Trustees from the  
19                  names of active, life or retired members of this Association. None of the  
20                  appointees shall be a faculty member working for a school of dentistry more  
21                  than one day per week or a member of a state board of dental examiners or  
22                  jurisdictional dental licensing agency.
- 23                  b. Six (6) members who are active, life or retired members of this Association  
24                  and also active members of the American Association of Dental Boards shall  
25                  be selected by the American Association of Dental Boards. None of these  
26                  members shall be a member of a faculty of a school of dentistry.
- 27                  c. Three (3) members who are active, life or retired members of this Association  
28                  and also active members of the American Dental Education Association shall  
29                  be selected by the American Dental Education Association. None of these  
30                  members shall be a member of any state board of dental examiners or  
31                  jurisdictional dental licensing agency.
- 32                  ~~d. One (1) member who is a dental hygienist shall be selected by the American~~  
33                  ~~Dental Hygienists' Association.~~
- 34                  ~~e. One (1) member who is a public representative shall be selected by the Joint~~  
35                  ~~Commission on National Dental Examinations.~~
- 36                  ~~f. One (1) member who is a dental student shall be selected annually by the~~  
37                  ~~American Student Dental Association.~~
- 38
- 39                  3. Commission for Continuing Education Provider Recognition. The number of and  
40                  the method of selection of members of the Commission for Continuing Education  
41                  Provider Recognition shall be governed by the Rules of the Commission for  
42                  Continuing Education Provider Recognition, except that six (6) members shall be  
43                  selected as follows: ~~The Commission for Continuing Education Provider~~  
44                  ~~Recognition shall be composed of sixteen (16) members selected as follows:~~
- 45                  a. Four (4) members who shall be appointed by the Board of Trustees from the  
46                  names of active, life or retired members of this Association. None of the  
47                  appointees shall be a faculty member working for a school of dentistry more  
48                  than one day per week or a member of a state board of dental examiners or  
49                  jurisdictional dental licensing agency. ~~Four (4) members shall be selected~~  
50                  ~~from nominations of active, life or retired members of this Association, with the~~  
51                  ~~nominations open to all trustee districts. At least two (2) of the members~~  
52                  ~~nominated appointed shall be general dentists, who shall be selected from~~  
53                  ~~nominations open to all trustee districts from the active, life or retired~~

- 1 ~~members of the Association. These members shall be nominated by the~~  
2 ~~Board of Trustees and elected by the House of Delegates.~~  
3 b. One (1) member who is an active member of the American Association of  
4 Dental Boards and also, if eligible, an active, life or retired member of this  
5 Association shall be selected by the American Association of Dental Boards.  
6 c. One (1) member who is an active member of the American Dental Education  
7 Association and also, if eligible, an active, life or retired member of this  
8 Association shall be selected by the American Dental Education Association.  
9 ~~d. One (1) member who is an active member of the American Society of~~  
10 ~~Constituent Dental Executives and also, if eligible, an active, life or retired~~  
11 ~~member of this Association shall be selected by the American Society of~~  
12 ~~Constituent Dental Executives.~~  
13 ~~e. One (1) member who is an active, life or retired member of this Association~~  
14 ~~shall be selected by the sponsoring organization of each ADA dental specialty~~  
15 ~~recognized by the ADA.\*~~  
16  
17 4. National Commission on Recognition of Dental Specialties and Certifying Boards.  
18 The National Commission on Recognition of Dental Specialties and Certifying  
19 Boards shall be composed of members selected as follows:  
20 a. One (1) specialist from each dental specialty recognized by this Association or  
21 Commission who is an active, life or retired member of this Association  
22 appointed by the sponsoring organization for that specialty.  
23 b. A number of general dentists equal to the number of members appointed  
24 pursuant to subsection 4.a. of this Section who are active, life or retired  
25 members of this Association appointed by the Board of Trustees.  
26 c. A member of the general public appointed by the Commission.\*  
27  
28 5. Amendment. The entirety of this Section A of Chapter IX is amendable by a two-  
29 thirds (2/3) affirmative vote of delegates present and voting provided that the  
30 proposed amendment(s) shall have been presented in writing at a previous  
31 session or a previous meeting of the same session of the House of Delegates.

32 \* To achieve the desired staggering of member terms for continuity, the initial terms of the members of the  
33 National Commission on Recognition of Dental Specialties and Certifying Boards shall be as set forth in  
34 Appendix 2 that accompanied Resolution 30H-2017 that established this Commission. This footnote shall  
35 expire without further action at the adjournment sine die of the 2021 House of Delegates.

### 36 BOARD RECOMMENDATION: Vote Yes.

### 37 Vote: Resolution 19

BLACK	Yes	GEHANI	Yes	KLEMMEDSON	Yes	RODRIGUEZ	Yes
COHLMIA	Yes	HARRINGTON	Yes	KYGER	Yes	SABATES	No
DOROSHOW	Yes	HERRE	Yes	LEARY	Yes	SHEPLEY	Yes
EDGAR	Yes	HIMMELBERGER	Yes	MCDUGALL	Yes	STEPHENS	Yes
FISCH	Yes	HUOT	Yes	NORBO	Yes	THOMPSON	Yes

Resolution No. 20 NewReport: Board Report 5 Date Submitted: June 2019Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

**AMENDMENTS TO CHAPTER IX, SECTION B OF THE ADA GOVERNANCE MANUAL****Background:** (See Report 5 of the Board of Trustees to the House of Delegates)**Resolution**

**20. Resolved,** that *ADA Governance Manual*, Chapter IX. Commissions, Section B. Removal for Cause be amended to grant the commissions sole authority to remove a commissioner for cause as follows (new language underscored, deletions ~~stricken~~):

**B. Removal for Cause.**

1. ~~Any of the The Commission-commissions of this Association on Dental Accreditation~~ shall have the sole authority to remove a ~~Commission on Dental Accreditation~~ any of its members for cause pursuant to the ~~its Rules~~ Rules of the Commission on Dental Accreditation, with notice of such removal being given.
- The Commission on Dental Accreditation shall provide notice to the ADA Board of Trustees ~~once the Commission acts to remove a member for cause.~~
2. ~~The Board of Trustees may remove a member of the Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission for Recognition of Dental Specialties and Certifying Boards for cause in accordance with procedures established by the Board of Trustees, which procedures shall provide for notice of the charges, including allegations of the conduct purported to constitute each violation, and a decision in writing which shall specify the findings of fact which substantiate any and all of the charges. Prior to issuance of the decision of the Board of Trustees, no commission member shall be excused from attending any meeting of a commission unless there is an opportunity to be heard or compelling reasons exist which are specified in writing by the Board of Trustees.~~

**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 21 NewReport: Board Report 5 Date Submitted: June 2019Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

**AMENDMENTS TO CHAPTER IX, SECTION C OF THE ADA GOVERNANCE MANUAL****Background:** (See Report 5 of the Board of Trustees to the House of Delegates)**Resolution**

**21. Resolved,** that the *ADA Governance Manual*, Chapter IX. Commissions, Section C. Eligibility be amended to grant a commission chair the sole authority to declare a position vacant when a commission member ceases to be a member of the selecting organization as follows (new language underscored, deletions ~~stricken~~):

**C. Eligibility.**

1. All members of commissions who are dentists must be active, life or retired members in good standing of this Association if eligible, except as otherwise provided in the *Bylaws*.
2. ~~A member of the Joint Commission on National Dental Examinations selected by the American Association of Dental Boards who ceases to be an active member of that organization may continue as a member of the Joint Commission on National Dental Examinations for the balance of that member's term.~~
3. ~~If a commission member of one of the Joint Commission on National Dental Examinations selected by the American Dental Education Association ceases to be a member of the organization that selected or elected the commission member, that commission member's faculty of a member school of that organization, the membership on the commission Joint Commission on National Dental Examinations shall terminate, and the President of this Association Chair of the commission shall declare the position vacant.~~
- 3.4. Any organizations that select members to serve on the Commission for Continuing Education Provider Recognition and offer continuing dental education courses must be recognized as a continuing education provider by the commission.
- 4.5. ~~No member of a commission may serve concurrently as a member of a council or another commission.~~
- 5.6. ~~A member shall not be eligible for appointment to another commission or council for a period of two (2) years after completing a previous commission or council appointment.~~

- 1 **BOARD RECOMMENDATION: Vote Yes.**
- 2 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
- 3 **BOARD DISCUSSION)**

Resolution No. 22 NewReport: Board Report 5 Date Submitted: June 2019Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

**AMENDMENTS TO CHAPTER IX, SECTION E OF THE ADA GOVERNANCE MANUAL****Background:** (See Report 5 of the Board of Trustees to the House of Delegates)**Resolution**

**22. Resolved**, that the ADA *Governance Manual*, Chapter IX. Commissions, Section E. Consultants, Advisors, and Staff be amended to grant the commissions authority to appoint consultants to assist in the administration of their respective programs as follows (new language underscored, deletions ~~stricken~~):

**E. Consultants, Advisers and Staff.****1. Consultants and Advisers.**

- a. The Commission on Dental Accreditation shall have the power to appoint consultants to assist in developing requirements and guidelines for conducting the accreditation program and accreditation evaluations, including site visitations, of predoctoral, advanced ~~dental education~~, and allied dental education programs.
- b. ~~The Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission on Recognition of Dental Specialties and Certifying Boards shall have the authority to nominate consultants and advisers in conformity with rules and regulations established by the Board of Trustees except as otherwise provided in the Bylaws or this Governance Manual.~~ The Joint Commission on National Dental Examinations also shall have the power to appoint select consultants to serve on the commission's test construction teams committees and to assist with test administration, test development, test security and test psychometric evaluation.
- c. The Commission for Continuing Education Provider Recognition shall have the power to appoint consultants to assist in developing standards and procedures, conducting recognition reviews and conducting appeals.
- d. The National Commission on Recognition of Dental Specialties and Certifying Boards shall have the power to appoint consultants to assist in the periodic review of dental specialties, the annual review of dental specialty certifying boards, and in conducting appeals.

- 1                                2. Staff. The Executive Director shall employ the staff of commissions, in the event  
2                                they are employees, and shall select the titles for commission staff positions.

3    **BOARD RECOMMENDATION: Vote Yes.**

4    **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**  
5    **BOARD DISCUSSION)**

Resolution No. 23 NewReport: Board Report 5 Date Submitted: June 2019Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

**AMENDMENTS TO CHAPTER IX, SECTION H OF THE ADA GOVERNANCE MANUAL****Background:** (See Report 5 of the Board of Trustees to the House of Delegates)**Resolution**

**23. Resolved,** that the *ADA Governance Manual*, Chapter IX. Commissions, Section H. Meetings of Commissions be amended to grant the commissions authority to conduct meetings in accordance with their *Rules* as follows (new language underscored, deletions ~~stricken~~):

H. Meetings of Commissions. Each commissions shall conduct meetings in accordance with its *Rules*. Commissions ~~The Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission on Recognition of Dental Specialties and Certifying Boards~~ shall hold at least one regular meeting annually, ~~provided that funds are available in the budget for that purpose or unless otherwise directed by the Board of Trustees.~~ Meetings may be held at the ADA Headquarters Building, the ADA Washington Office or from multiple remote locations through the use of a conference telephone or other communications equipment by means of which all members can communicate with each other. ~~Such meetings shall be conducted in accordance with rules and procedures established by the Board of Trustees. The Commission on Dental Accreditation shall conduct meetings in accordance with rules and procedures pursuant to the *Rules of the Commission on Dental Accreditation.*~~

**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 24 NewReport: Board Report 5 Date Submitted: June 2019Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None

Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_

Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

**AMENDMENTS TO CHAPTER IX, SECTION I OF THE ADA GOVERNANCE MANUAL****Background:** (See Report 5 of the Board of Trustees to the House of Delegates)**Resolution**

**24. Resolved,** that the *ADA Governance Manual* Chapter IX. Commissions, Section I. Quorum be amended to grant the commissions the authority to define a quorum for meetings as follows (new language underscored, deletions ~~stricken~~):

I. Quorum. ~~A majority of the members of the Joint Commission on National Dental Examinations, the Commission on Continuing Education Provider Recognition, and the National Commission on Recognition of Dental Specialties and Certifying Boards shall constitute a quorum.~~ Quorum requirements for each the Ccommissions on Dental Accreditation shall be as stated in the *Rules of the Commission on Dental Accreditation* of that commission.

**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 25 NewReport: Board Report 5 Date Submitted: June 2019Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

**AMENDMENTS TO CHAPTER IX, SECTION L OF THE ADA GOVERNANCE MANUAL****Background:** (See Report 5 of the Board of Trustees to the House of Delegates)**Resolution**

**25. Resolved,** that the ADA *Governance Manual* Chapter IX. Commissions, Section L. Power to Adopt Rules be amended to grant the commissions the authority to adopt rules as follows (new language underscored, deletions ~~stricken~~):

L. Power to Adopt Rules. Any commission of this Association shall have the power to adopt rules for such commission and amendments thereto, provided such rules and amendments thereto do not conflict with or limit the *Constitution and Bylaws*, *Governance and Organizational Manual* and *Standing Rules for Councils and Commissions* of this Association. ~~Rules and amendments thereto, adopted by the Joint Commission on National Dental Examinations and Commission for Continuing Education Provider Recognition, shall not be effective until submitted in writing to and approved by majority vote of the House of Delegates of this Association, except the Joint Commission on National Dental Examinations shall have such bylaws and amendments thereto as the House of Delegates of this Association may adopt by majority vote for the conduct of the purposes and management of the Joint Commission on National Dental Examinations. The Commission on Dental Accreditation and the National Commission on Recognition of Dental Specialties and Certifying Boards~~ Commissions shall have the power to adopt rules and amendments thereto pursuant to a two-thirds affirmative vote of the members present and voting. ~~The Commission for Continuing Education Provider Recognition shall have the authority to make corrections in punctuation, grammar, spelling, name changes, gender references, and similar editorial corrections to their Rules which do not alter context or meaning without the need to submit such editorial corrections to the House of Delegates. Such corrections shall be made only by a unanimous vote of the commission adopting such editorial correction.~~

**1 BOARD RECOMMENDATION: Vote Yes.****2 Vote: Resolution 25**

BLACK	Yes	GEHANI	Yes	KLEMMEDSON	Yes	RODRIGUEZ	Yes
COHLMIA	Yes	HARRINGTON	Yes	KYGER	Yes	SABATES	No
DOROSHOW	Yes	HERRE	Yes	LEARY	Yes	SHEPLEY	Yes
EDGAR	Yes	HIMMELBERGER	Yes	MCDUGALL	Yes	STEPHENS	Yes
FISCH	Yes	HUOT	Yes	NORBO	Yes	THOMPSON	Yes

**3**

Resolution No. None N/AReport: Board Report 6 Date Submitted: June 2019Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

**REPORT 6 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: ASSESSMENT OF  
THE EFFECTIVENESS OF THE COMMISSION FOR CONTINUING EDUCATION PROVIDER  
RECOGNITION RESOLUTIONS BY THE BOARD OF TRUSTEES PURSUANT TO  
RESOLUTION 6H-2014**

**Background:** In 2014, the House passed Resolution 6H-2014 (*Trans.*2014:446) creating the Commission on Continuing Education Provider Recognition (CCERP). Resolution 6H provides:

Amendment of the *Bylaws* to Establish the Commission for Continuing Education Provider Recognition and Approval of the Rules of the ADA Commission for Continuing Education Provider Recognition

**6H-2014-Resolved**, that ADA *Bylaws* be amended as shown in Appendix 1 of the Council on Dental Education and Licensure's 2014 annual report (*Reports*:114 and *Worksheet*:4015) establishing the Commission for Continuing Education Provider Recognition, and be it further

**Resolved**, that the Rules of the ADA Commission for Continuing Education Provider Recognition as shown in Appendix 2 of the Council on Dental Education and Licensure's 2014 annual report (*Reports*:119 and *Worksheet*:4020) be approved, and be it further

**Resolved**, that the Board of Trustees conduct a review of the ADA Commission for Continuing Education Provider Recognition in 2019 assessing its effectiveness and report findings to the 2019 House of Delegates, and be it further

**Resolved**, that Resolution 82H-1996 and Resolution 5H-2007 be rescinded.

In order to carry out its responsibilities under this resolution, in 2018, the Board asked for a self-assessment of its effectiveness as a new commission. The Board adopted Resolution B-99-2018 to make this request:

**B-99-2018. Resolved**, that the Board asks CCEPR to provide the Board's Governance Committee with a report assessing CCEPR's effectiveness by the May, 2019 Board meeting, and be it further

**Resolved**, that CCEPR is asked to include in its assessment the following elements:

- 1 • Review of CCEPR Bylaws Duties: Is the Commission fulfilling its Bylaws responsibilities
- 2 to:
- 3     ▪ Develop standards for continuing dental education
- 4     ▪ Approve CE providers that meet those standards
- 5     ▪ Provide a means for an appeal process
- 6     ▪ Submit annual report and annual budgets to House of Delegates
- 7     ▪ Submit revisions to the CCEPR Rules to the House (except for editorial changes)
- 8 • CCEPR's own self-assessment to include assessment of:
- 9     ▪ CCEPR mission, vision, values (adopted 2016)
- 10     ▪ CCEPR strategic plan (adopted 2017)
- 11     ▪ Commission's self-assessment process to include review of strategic plan
- 12         dashboard, CCEPR member surveys to assess organizational structure,
- 13         operations, capacity, etc., facilitated discussion (process to be conducted August
- 14         2018-April 2019, with report to House completed by June 2019)
- 15 • Evaluation of Continuing Education Recognition Program (CERP)
- 16     ▪ Standards—benchmarked against other accrediting agencies for CE in the health
- 17         professions
- 18     ▪ Program acceptance by state dental boards, other agencies
- 19     ▪ Participation: size and scope of enterprise (number of providers, CE activities,
- 20         hours of instruction)
- 21     ▪ CERP provider surveys
- 22     ▪ Financial assessment

23 CCERP complied with the Board's request and forwarded to the Board's Governance Committee a report  
24 on its self-assessment. A copy of that report, including its executive summary, is attached to this report as  
25 Appendix A.

26 The Governance Committee of the Board of Trustees reviewed CCEPR's self-assessment report and felt  
27 it was a thorough and well-done assessment of the commission's effectiveness. Both the Committee and  
28 the Board shares the commission's conclusions summarized in the executive summary of its report:

29 The Commission's self-assessment affirms the following:

- 30 • The Commission effectively fulfills its *Bylaws* duties through ongoing administration of the
- 31 ADA Continuing Education Recognition Program (CERP), established procedures for
- 32 conducting appeals of adverse recognition actions, and timely submission of reports and
- 33 budgets to the ADA House of Delegates.
- 34 • The work of the Commission in setting standards for continuing dental education and
- 35 approving providers, aligns with and supports the ADA's vision of "empowering the dental
- 36 professional to achieve optimal health for all."
- 37 • CCEPR's configuration as a semi-autonomous commission within the ADA governance
- 38 structure gives the agency the authority to independently set standards for continuing dental
- 39 education and approve providers with minimal conflicts of interest, supporting the trust the
- 40 public places in the profession to regulate itself. The broad representation of stakeholder
- 41 groups that comprise the Commission helps ensure balanced, peer review processes.
- 42 • Through adoption of a mission statement and implementation of a strategic plan, the
- 43 Commission is undertaking to enhance operations and help ensure that ADA CERP
- 44 continues to implement consistent, valid practices that are aligned with best practices in
- 45 continuing education in other health professions.
- 46 • Participation in ADA CERP has increased by 7% in the last five years with 470 providers
- 47 currently approved. Revenues from CERP provider fees have increased as a result of higher
- 48 participation levels and a restructuring of provider fees.
- 49 • In 2017, CERP recognized providers offered over 37,884 unique CE activities, offering a total
- 50 of over 228,567 hours of instruction. 77% of members responding to a January 2019

1 Advisory Circle survey indicated that CERP is a moderately or very valuable ADA program.  
2 However, only 69% of respondents indicated that they sometimes, usually or always search  
3 for CE offered by CERP recognized provider. Improving member awareness of the program  
4 may help increase this percentage.

- 5 • With an increase in the number of program participants and applications submitted, the  
6 Commission's capacity to absorb additional work and maintain timely and efficient operations  
7 is being challenged. The Commission will explore options for reducing the workload on  
8 individual Commissioners, however these may involve additional human resource needs.

9 In summary, the Commission's structure and composition support its ability to administer ADA  
10 CERP in accordance with best practices for agencies with responsibility for developing and  
11 implementing accreditation standards that promote and monitor continuous quality improvements  
12 of continuing education in the health professions. To enhance its effectiveness and continue  
13 improving processes for reviewing and monitoring CE, the Commission must consider available  
14 options to support program expansion.

15  
16 The Board of Trustees thanks the CCEPR volunteers and staff for their hard work in establishing and  
17 operating this important commission.

### 18 Resolutions

19  
20  
21 This report is informational and no resolutions are presented.

22  
23 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

24  
25 **BOARD VOTE: UNANIMOUS.**

**APPENDIX A****COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION  
SELF-ASSESSMENT REPORT**

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

**Executive Summary**

The Commission for Continuing Education Provider Recognition (CCEPR) was established by Res. 6H-2014 (*Trans.* 2014:466) as the ADA agency responsible for developing standards for continuing dental education (CE) and approving providers of CE that meet those standards. The Commission fulfills its responsibilities by administering the ADA Continuing Education Recognition Program (CERP), a program formerly overseen by the Council on Dental Education and Licensure (CDEL). Res. 6H-2014 also directed the Board of Trustees to conduct a review of the ADA Commission for Continuing Education Provider Recognition in 2019 assessing its effectiveness and to report its findings to the 2019 House of Delegates. To assist the Board in fulfilling this request, the Board has asked CCEPR to provide the Board's Governance Committee with a report assessing CCEPR's effectiveness by the May, 2019 Board meeting (B-99-2018).

The Commission has provided the attached report summarizing a multi-faceted self-assessment process conducted from August 2018-April 2019.

**Key Issues:** The Commission's self-assessment affirms the following:

- The Commission effectively fulfills its *Bylaws* duties through ongoing administration of the ADA Continuing Education Recognition Program (CERP), established procedures for conducting appeals of adverse recognition actions, and timely submission of reports and budgets to the ADA House of Delegates.
- The work of the Commission in setting standards for continuing dental education and approving providers, aligns with and supports the ADA's vision of "empowering dental professionals to achieve optimal oral health for all."
- CCEPR's configuration as a semi-autonomous commission within the ADA governance structure gives the agency the authority to independently set standards for continuing dental education and approve providers with minimal conflicts of interest, supporting the trust the public places in the profession to regulate itself. The broad representation of stakeholder groups that comprise the Commission helps ensure balanced, peer review processes.
- Through adoption of a mission statement and implementation of a strategic plan (Appendices 1 and 2), the Commission is undertaking to enhance operations and help ensure that ADA CERP continues to implement consistent, valid practices that are aligned with best practices in continuing education in other health professions.
- Participation in ADA CERP has increased by 7% in the last five years with 470 providers currently approved. Revenues from CERP provider fees have increased as a result of higher participation levels and a restructuring of provider fees.
- In 2017, CERP recognized providers offered over 37,884 unique CE activities, offering a total of over 228,567 hours of instruction. 77% of members responding to a January 2019 Advisory Circle survey indicated that CERP is a moderately or very valuable ADA program. However, only 69% of respondents indicated that they sometimes, usually or always search for CE offered by CERP recognized provider. Improving member awareness of the program may help increase this percentage.

- With an increase in the number of program participants and applications submitted, the Commission's capacity to absorb additional work and maintain timely and efficient operations is being challenged. The Commission will explore options for reducing the workload on individual Commissioners, however these may involve additional human resource needs.

In summary, the Commission's structure and composition support its ability to administer ADA CERP in accordance with best practices for agencies with responsibility for developing and implementing accreditation standards that promote and monitor continuous quality improvements of continuing education in the health professions. To enhance its effectiveness and continue improving processes for reviewing and monitoring CE, the Commission must consider available options to support program expansion.

**Budget Impact/Financial or Operational Requirements:** Revenues from ADA CERP provider fees offset the Commission's direct costs and a portion of indirect costs. Indirect costs are not currently calculated in the Commission's budget. A shared services agreement with the ADA defining these services and costs could help the Commission establish and meet its financial objectives, and would affirm the ADA's commitment to providing these services.

**Risk/Benefit:** This report was prepared to assist the Board of Trustees in assessing the Commission for Continuing Education Provider Recognition.

**Action Desired:** None.

Appendix 1. CCEPR Mission, Vision and Values

Appendix 2. CCEPR Strategic Plan

Prepared by: Mary Borysewicz, director, Commission for Continuing Education Provider Recognition,  
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CCEPR Chair: Nancy R. Rosenthal, DDS

## COMMISSION FOR CONTINUING EDUCATION PROVIDER RECOGNITION SELF-ASSESSMENT REPORT

**Background:** The Commission for Continuing Education Provider Recognition (CCEPR) was established by Res. 6H-2014 (*Trans.* 2014:466) as the ADA agency responsible for developing standards for continuing dental education (CE) and approving providers of CE that meet those standards. The Commission fulfills its responsibilities by administering the ADA Continuing Education Recognition Program (CERP), a program formerly overseen by the Council on Dental Education and Licensure (CDEL). The 2014 House of Delegates' action to move oversight of CERP to an ADA commission was based on the principle that a commission structure:

- Reflects a best practice for recognition and accreditation programs by establishing a governance structure that minimizes the possibility of direct conflicts of interest;
- Enhances an ADA program that sets standards designed to help dentists excel throughout their careers; and
- Involves representatives from all disciplines of dentistry in program oversight.

Res. 6H-2014 also directed the Board of Trustees to conduct a review of the ADA Commission for Continuing Education Provider Recognition in 2019 assessing its effectiveness and report findings to the 2019 House of Delegates. In fulfilling this request, the Board approved Res. B-99-2018 which states:

**B-99-2018. Resolved**, that the Board asks CCEPR to provide the Board's Governance Committee with a report assessing CCEPR's effectiveness by the May, 2019 Board meeting; and be it further

**Resolved**, that CCEPR is asked to include in its assessment the following elements:

- Review of CCEPR *Bylaws* Duties: Is the Commission fulfilling its *Bylaws* responsibilities to:
  - Develop standards for continuing dental education
  - Approve CE providers that meet those standards
  - Provide a means for an appeal process
  - Submit annual report and annual budgets to House of Delegates
  - Submit revisions to the CCEPR Rules to the House (except for editorial changes)
- CCEPR's own self-assessment to include assessment of:
  - CCEPR mission, vision, values (adopted 2016)
  - CCEPR strategic plan (adopted 2017)
  - Commission's self-assessment process to include review of strategic plan dashboard, CCEPR member surveys to assess organizational structure, operations, capacity, etc., facilitated discussion (process to be conducted August 2018-April 2019, with report to House completed by June 2019)
- Evaluation of Continuing Education Recognition Program (CERP)
  - Standards—benchmarked against other accrediting agencies for CE in the health professions
  - Program acceptance by state dental boards, other agencies
  - Participation: size and scope of enterprise (number of providers, CE activities, hours of instruction)
  - CERP provider surveys
  - Financial assessment

Pursuant to this request, and in compliance with Res. 1H-2013 which requires all ADA Councils and Commissions to conduct a self-assessment, CCEPR has conducted a multi-faceted self-assessment. The Commission offers the following summary of its process and conclusions.

## CCEPR Self-Assessment

In 2016, the Commission adopted mission, vision and values statements reflecting the Commission's unique responsibilities under ADA *Bylaws* and its alignment with the ADA's mission, vision and values. (Appendix 1).

In 2017, the Commission formulated a strategic plan to support the Commission in fulfilling its *Bylaws* responsibilities and advancing its mission (Appendix 2), and established a Planning and Assessment Committee. The Committee is charged with monitoring the Commission's strategic plan, with reports and recommendations to the Commission on a regular basis, and assisting the Commission with conducting periodic self-assessments. The 2018-2019 self-assessment process approved by the Commission included: (1) a survey of current and former Commissioners; (2) a review of *Bylaws* duties and governance documents; (3) a review of the Commission's strategic plan; and (4) consideration of key aspects of the ADA Continuing Education Recognition Program (CERP).

Through its discussions and reviews, the Commission reflected on the following:

- Does the current governance structure optimally support the Commission's ability to fulfill its *Bylaws* duties?
- Is the Commission's strategic plan advancing the Commission's mission?
- Do the Commission's organizational structures, meetings, staffing, etc., support efficient and effective operation of Commission business and CERP administration?
- Does ADA CERP demonstrate that it meets program goals and objectives?

***Bylaws* responsibilities:** ADA *Bylaws* (Chapter IX, Sec. 30.C) state that the duties of the Commission shall be to:

- a. Formulate and adopt requirements, guidelines and procedures for the recognition of continuing dental education providers.
- b. Approve providers of continuing dental education programs and activities.
- c. Provide a means for continuing dental education providers to appeal adverse recognition decisions.
- d. Submit an annual report to the House of Delegates of this Association and interim reports, on request, and the Commission's annual budget to the Board of Trustees of the Association.
- e. Submit the Commission's rules and amendments thereto to this Association's House of Delegates for approval by majority vote either through or in cooperation with the Council on Dental Education and Licensure.

Members of the Commission are in strong agreement that CCEPR provides a valuable service to the profession in setting standards for quality continuing dental education that promotes evidence based practice, patient safety and improvements in oral health, and by approving providers that meeting those standards. Through its administration of ADA CERP, the Commission believes that it not only satisfies its *Bylaws* duties, but also fills an important role by offering guidance and peer review to providers of CE, and by assuring dental professionals and regulatory agencies that providers approved through CERP meet defined standards for quality CE. Details regarding CERP are provided later in this report.

In 2015, the Commission established a separate Appeal Board in accordance with the [CCEPR Rules](#) that were approved by the 2014 House of Delegates, and approved revisions to the CERP Procedures for an Adverse Action. The Procedures provide a mechanism by which providers that receive an adverse recognition action, defined as a decision by the Commission to deny or withdraw recognition, are assured of due process and consideration by an independent entity.

The Commission fulfills its remaining *Bylaws* duties by submitting timely reports and budgets to the ADA House of Delegates.

**Governance considerations:** The Commission believes that its configuration as a commission under ADA governance is appropriate. The work of the Commission in setting standards for continuing dental education and approving providers aligns with, and supports, the ADA's vision of "empowering the dental professional to achieve optimal oral health for all." Additionally, in order to maintain the public trust, a commission must be administered and must make decisions in a consistent manner that is free from bias and conflict of interest. As the ADA agency with the sole authority to promulgate standards and criteria for CE and approve providers that meet them, the Commission endeavors to protect the public and the profession with integrity, confidentiality protections, and due process. This also supports the long-term viability of the profession's ability to be self-regulating.

The Commission's current composition of sixteen members includes a broad representation of organizations with an interest in ensuring quality CE, including the ADA, the recognized dental specialties, dental boards, and dental educators.

The Commission has received information regarding proposals to revise ADA governance documents to ensure consistency in the governance and operations of the ADA commissions where appropriate, and to ensure that the commissions have the authority to administer their responsibilities with appropriate autonomy. Among the changes proposed to the composition of CCEPR as set forth in the ADA Governance and Organizational Manual is the addition of a public member to CCEPR. Unlike the other three ADA commissions, CCEPR does not currently include a public member. The Commission is supportive of this change and has authorized the chair to appoint a committee to recommend criteria and procedures for the appointment of a public member.

With the recognition of dental anesthesiology by the National Commission for the Recognition of Dental Specialties and Certifying Boards, the Commission has noted that a representative from this tenth dental specialty may also be added to CCEPR, pending conforming revisions to the ADA *Governance Manual*.

Through its self-assessment process, the Commission has questioned whether it has the optimal number of members to conduct its work. The expansion of the Commission to include additional members may help to address this in part.

**CCEPR strategic plan:** In 2017, the Commission identified strategic priorities and goals to help advance its mission over the next four years (Appendix 2). Ongoing initiatives include:

- A comprehensive revision of the CERP Recognition Standards to ensure that the Standards establish valid and reliable criteria for effective continuing dental education that supports enhanced professional effectiveness and improvements in patient care
- The development of an online accreditation platform within Aptify that will streamline CERP application submissions and fee payments, and that will support online review processes and enhanced audits of CE providers' compliance with program requirements
- Implementing measures to support the Commission's financial sustainability, by increasing revenues and conducting a more comprehensive analysis of the Commission's expenses, including indirect costs for shared services

At a midpoint review of its strategic plan in April 2019, the Commission noted that progress towards these goals was being made, although some target dates have been adjusted. The Commission affirmed that these should remain priorities. As funding for the online CERP application platform in Aptify was approved in the 2019 ADA budget, and preliminary work on this project has begun, the Commission anticipates that an online application may be available by the end of 2020. However, development of a registry to capture data on providers' individual CE activities, which will enhance the Commission's ability to monitor providers, will occur in a later phase of the Aptify project; therefore, this objective will be carried over to the next strategic plan.

1 In assessing whether it has the organizational capacity to meet its administrative needs, the Commission  
2 has noted that it may not have adequate volunteer and staff support to provide the highest level of service  
3 to ADA CERP program participants. With an increase in the number of CERP applications to be  
4 processed, the volunteer workload has increased correspondingly. The Commission will explore options  
5 for reducing the number of applications reviewed by each volunteer, such as increasing the number of  
6 consultants, expanding staff's role in screening submissions, and/or changing the timing of review cycles.  
7 The Commission has also noted that additional staff support may be needed in order to achieve several  
8 of its priorities in the next few years, including: expanded marketing of ADA CERP; increased education  
9 outreach and resources for CE providers; development and testing of an online application and review  
10 portal; and development of infrastructure to enhance monitoring program participants' compliance with  
11 CERP Standards.]  
12

13 **Commission operations:** Commission members were surveyed regarding their perceptions of the  
14 effectiveness of meetings, operations and staff support. The Commission believes that meeting twice per  
15 year is appropriate, and is not supportive of reducing the number of in person meetings.  
16

17 In general, the Commission believes that it has sufficient resources to conduct its business, however a  
18 significant number of Commissioners responding to the survey do not believe that the Commission has  
19 sufficient staff support. No suggestions were made that work that is currently done by staff should be  
20 conducted by volunteers.  
21

22 The Commission believes that it has reached capacity in the number of CERP applications that can be  
23 reviewed by the current number of Commissioners and consultants available. In order for ADA CERP to  
24 grow, both in terms of the number of participating programs and in the level of service, education and  
25 outreach needed to support quality improvements, the Commission will need to consider several options  
26 for reducing the workload on individual Commissioners, as described above. The number of providers  
27 participating in ADA CERP has increased 16% in the last ten years, however the number of  
28 Commissioners has remained the same as the number of members on its predecessor, the CERP  
29 Committee; the number of consultants, currently limited to volunteers who previously served on the  
30 Commission, is limited. The number of staff supporting CERP and the Commission has remained at two  
31 FTE for more than 15 years.  
32

33 **Effectiveness of ADA CERP:** The objectives of the Continuing Education Recognition Program are to:  
34

- 35 • Improve the educational quality of CE programs through self-evaluations conducted by the CE  
36 provider in relation to the CERP Standards, and through counsel and recommendations to the CE  
37 providers from the Commission
- 38 • Assure participants that recognized CE providers have the organizational structure and resources  
39 to provide CE activities of acceptable educational quality
- 40 • Promote uniform standards for continuing dental education that can be accepted nationally by the  
41 dental profession
- 42 • Assist regulatory agencies and other organizations in identifying providers whose activities are  
43 acceptable for credit toward licensure membership requirements

44 The Commission believes the program meets these objectives.  
45

46 **CERP Recognition Standards and Procedures:** The CERP Standards establish uniform criteria for CE  
47 providers. The CERP recognition procedures outline the requirements and processes for achieving and  
48 maintaining CERP recognition, and the application process is designed to support a provider's self-  
49 assessment with respect to the CERP Recognition Standards. The recognition process includes a peer  
50 review process of a provider's policies and practices for planning, implementing and evaluating  
51 educational activities, and offers feedback for improvements.

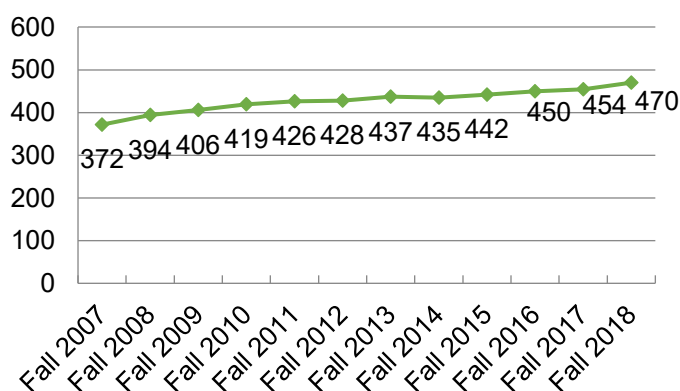
The Commission obtains feedback on the CERP application process from CE providers through regular surveys. Survey results are tracked annually and suggestions from applicants are considered during periodic updates of application materials. Survey responses indicate that providers find the application process rigorous.

The Commission is currently engaged in a comprehensive review and revision of the CERP Recognition Standards, in order to help ensure that the Standards continue to establish relevant criteria for continuing dental education that is scientifically sound, non-commercial, and that supports improvements in oral health care. The revision process has included surveys of stakeholders, open hearings, literature reviews, and benchmarking with accreditation standards for continuing education in other healthcare disciplines, including medicine, pharmacy, nursing, optometry, and psychology. The Commission has met with representatives from the Accreditation Council for Continuing Medical Education, the Accreditation Council for Pharmacy Education, and Joint Accreditation for Interprofessional Continuing Education, receiving information about those agencies' accreditation criteria and processes, and conducting comparisons with CERP Standards. The goals of the ongoing revision process are to simplify the Standards and to emphasize the principles and practices that contribute to effective continuing education. Focusing the Standards on educational outcomes which lead to improvements in professional performance and patient care will help align CERP with accreditation criteria in other health professions, and best practices in continuing professional development.

**Program acceptance:** Participation in ADA CERP is voluntary. All licensing jurisdictions in the United States and Canada accept credits from CERP recognized providers, subject to any limitations on subject matter or format imposed by each licensing jurisdiction. Credits from ADA CERP recognized providers are accepted by the Academy of General Dentistry for that organization's membership awards.

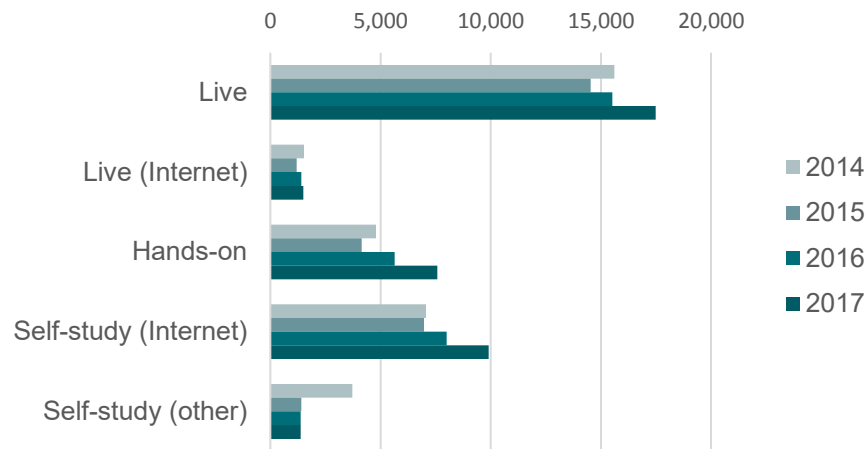
**Program participation:** At the time this report was written there were 470 ADA CERP recognized providers. From 2007 through 2018, the total number of CE providers participating in CERP has increased, with annual growth rates ranging from 0.5 – 3%, and cumulative growth of 7% in the last five years. Since opening the recognition process to providers outside the U.S. and Canada in 2002, the percentage of CERP recognized providers that are international has grown to 5% of all recognized providers.

**Figure 1. Number of CERP Recognized Providers**

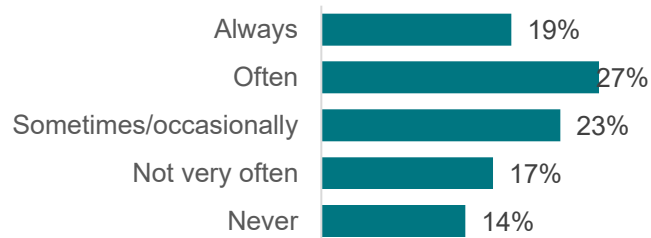
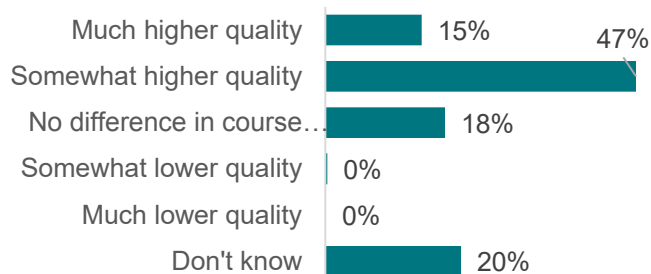


An additional 102 local and regional providers are approved through the Extended Approval Process.

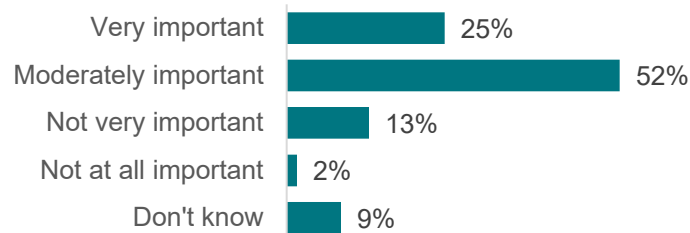
Through the 2018 CERP provider annual survey, providers reported that in 2017 they offered a combined total of over 37,884 unique CE activities, offering a total of over 228,567 hours of instruction.

**Figure 2. CE Activities Offered by CERP Recognized Providers**

**ADA member awareness of CERP:** A January 2019 survey of ADA Advisory Circle members (1100 members surveyed; 724 total responses; response rate of 62%) indicates that ADA members are familiar with the ADA CERP logo and believe the program to be a valuable member benefit. A majority of respondents indicated that when looking for CE activities they sometimes, often or always look for courses offered by CERP providers, and believe that CE activities offered by CERP recognized providers are of higher quality than other CE courses.

**Figure 3. When searching for a CE course to attend, how often do you look for courses offered by ADA CERP recognized providers?****Figure 4. Do you believe courses offered by CERP recognized providers are of higher or lower quality than other CE courses?**

**Figure 5. As an ADA member benefit, how important do you think the CERP program is in comparison to other member benefits (such as advocacy, annual meeting, ADA.org, etc.)?**



**Finances:** ADA CERP provider fees are the primary source of the Commission's revenues. In 2019, the Commission introduced a new fee structure for CERP recognized providers. Re-application fees were eliminated and annual fees increased. Under the new structure, CERP provider annual fees are based on the size of the providers' CE programs, determined by the number of CE participants in the provider's CE activities each year. Based on the new fee structure, the Commission projects an increase in revenues over previously budgeted income.

**Table 6. CCEPR Budget**

	Actual		Budget		
	2017	2018	Budget 2018	Budget 2019	Proposed Budget 2020
Total Revenues	320,509	<b>347,700</b>	329,700	316,764	380,233
Total Direct Expense	300,969	<b>318,516</b>	319,615	325,351	296,007
<b>Net Revenue/(Expense)</b>	<b>19,540</b>	<b>29,184</b>	<b>10,085</b>	<b>(8,587)</b>	<b>46,006</b>

Current revenues offset the program's direct expenses (Commission expenses, meetings, travel and staff salaries and benefits), and a portion of indirect expenses. At this time, indirect expenses, for shared services such as IT and legal support are not calculated as part of the Commission's budget. A shared services agreement with the ADA defining these services and costs would help the Commission establish and meet its financial objectives, and would affirm the ADA's commitment to providing these services.

In summary, the Commission's structure and composition support its ability to administer ADA CERP in accordance with best practices for agencies with responsibility for developing and implementing accreditation standards that promote and monitor continuous quality improvements of continuing education in the health professions. To enhance its effectiveness and continue improving processes for reviewing and monitoring CE, the Commission must consider available options to support program expansion.

**Action Desired:** None.

Appendix 1. CCEPR Mission, Vision and Values

1 Appendix 2. CCEPR Strategic Plan 2017-2020

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6 CCEPR Chair: Nancy R. Rosenthal, DDS

Resolution No. 65 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Scientific Affairs

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

## PROPOSED AMENDMENT OF THE ADA POLICY ON EARLY DETECTION AND PREVENTION OF ORAL CANCER

**Background:** In spring 2019, the Council on Scientific Affairs (CSA) reviewed the ADA Policy Statement on Early Detection and Prevention of Oral Cancer (*Trans.*2014:506) and recommended amending this policy as presented in Resolution 65 (below). This policy review is in accordance with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.* 2012:370), which calls for all ADA policies to be reviewed on a five-year cycle.

As background, this ADA policy was last adopted in 2014 as an update of a previous ADA policy titled Prevention and Early Oral Cancer Detection (*Trans.*1996:681) [note: previous ADA oral cancer policies date back to the 1960s]. The CSA became lead agency for reviewing this ADA policy in 2016 by consensus agreement between CSA and the Council on Advocacy for Access and Prevention.

The CSA aims to ensure that the best available science is presented and reflected in ADA policies under its purview. For this policy review, the CSA worked to align recommendations that are presented in the ADA clinical practice guideline on evaluation of potentially malignant oral lesions,<sup>1</sup> as well as the ADA Policy on Human Papillomavirus (HPV) Vaccination for the Prevention of Infection with HPV Types Associated with Oropharyngeal Cancer (*Trans.*2018:351).

**Proposed Amendments to the 2014 ADA Policy Statement:** At its June 2019 meeting, the Council recommended the following as proposed revisions to the current ADA policy (in tracked-edit format below, with an accompanying rationale for each revision).

Proposed Revisions to the Policy (additions underlined; deletions struck through)	Rationale
Policy name/title: Early Detection and Prevention of Oral <u>and Oropharyngeal</u> Cancer	The Council recommends updating the title of this policy to make it broader in scope and more precisely focused by addressing early detection and prevention of both oral <u>and oropharyngeal</u> cancer (emphasis added). Expanding the scope of this policy is aligned with the increasing burden of oropharyngeal cancer, <sup>1,2</sup> and with the ADA policy support of the use and administration of HPV vaccination (newly adopted in 2018). The dental

	profession has witnessed the changing face of head and neck cancer over the past quarter century, <sup>1-3</sup> and the ADA's policy on early detection and prevention of these cancers must address both cancer types to be comprehensive.
<b>Resolved</b> , that the American Dental Association recognizes that early oral <u>and oropharyngeal</u> cancer diagnosis has the potential to have a significant impact on treatment decisions and outcomes, and supports routine visual and tactile examinations <u>for all adult (age 18 or older) patients, particularly for patients who are at risk including those who use tobacco or who are heavy consumers of alcohol, and be it further</u>	The Council recommends including oropharyngeal cancer considerations in each location that oral cancer is mentioned. To be fully aligned with the 2017 guideline on evaluation of potentially malignant oral lesions, <sup>1</sup> the revised recommendation is to support routine visual and tactile exams (VTEs) "for all adult (age 18 and older) patients." <sup>1</sup> This includes the parenthetical "(age 18 or older)" to make it clear that the recommendation applies to all adult patients.
<b>Resolved</b> , that the Association supports state and local Association-sponsored education activities to promote the prevention and early detection of oral <u>and oropharyngeal</u> cancer. <del>to those who use tobacco, alcohol or both.</del>	The Council recommended removing the latter phrasing from the 2014 policy because the Association's recommendation—and support—for routine visual and tactile exams should no longer be limited only to those people who were historically considered at highest risk for oral cancer, namely tobacco or alcohol users. The CDC currently estimates that 70% of oropharyngeal cancers are associated with the HPV virus. <sup>4</sup>

The Council presents these proposed policy revisions recognizing the importance of improved detection of oral and oropharyngeal cancers through improved examination processes, better regional symptom identification, and documentation of family disposition (e.g., genetic syndromes) or environmental risk factors. The Council also recognizes that survivors of head and neck cancer face challenges with breathing, swallowing, speaking, mucositis and pain.<sup>5</sup> While there is no clear-cut evidence that early detection will lead to increased survival (for individuals with OSCC), the Council continues to support routine conventional visual and tactile examinations (CVTE) for all adult patients age 18 or older, in accordance with the 2017 clinical practice guideline on the evaluation of potentially malignant disorders in the oral cavity.<sup>1</sup>

**Conclusion:** The Council recommends that the House of Delegates review the proposed revisions to the 2014 ADA Policy on Early Detection and Prevention of Oral Cancer (in tracked-edit format--above), and the proposed resolution to revise this policy, which is presented below.

Revising the scope and content of this policy will strengthen the ADA's policy advocacy and recommendations on early detection and prevention of oral and oropharyngeal cancer. The proposed policy revision will also provide stronger alignment of the ADA's policies pertaining to cancers of the oral cavity and oropharynx, which are a critical issue for the dental profession and the general public.

**References**

1. Lingen MW, Abt E, Agrawal N, et al. Evidence-based clinical practice guideline for the evaluation of potentially malignant disorders in the oral cavity: A report of the American Dental Association. J Am Dent Assoc 2017;148(10):712-27.e10.
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**Resolution**

**65. Resolved**, that the ADA Policy on Early Detection and Prevention of Oral Cancer (*Trans*.2014:460) be amended by deletion and addition as follows (additions underscored; deletions ~~stricken~~):

**Early Detection and Prevention of Oral and Oropharyngeal Cancer**

**Resolved**, that the American Dental Association recognizes that early oral and oropharyngeal cancer diagnosis has the potential to have a significant impact on treatment decisions and outcomes, and supports routine visual and tactile examinations for all adult (age 18 or older) patients, ~~particularly for patients who are at risk including those who use tobacco or who are heavy consumers of alcohol~~, and be it further

**Resolved**, that the Association supports state and local Association-sponsored education activities to promote the prevention and early detection of oral and oropharyngeal cancer. ~~to those who use tobacco, alcohol or both.~~

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 66 NewReport: N/A Date Submitted: July 2019Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

**AMENDMENT OF POLICY: CRITERIA FOR RECOGNITION OF A CERTIFICATION BOARD FOR DENTAL ASSISTANTS**

**Background:** In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.* 2012:370), the Council on Dental Education and Licensure has reviewed the policy, Criteria for Recognition of a Certification Board for Dental Assistants for accuracy and currency. In doing so, the Council sought input from the ADA recognized certification board, the Dental Assisting National Board (*Trans.* 1990:551; 2014:460). The Council also reviewed the eligibility pathways for taking the Certified Dental Assistant/General Chairside Assisting Exam and supported the action taken by the DANB Board of Directors to recognize graduation from a post-baccalaureate program affiliated with a U.S. or Canadian dental school as an additional way to meet DANB's CDA Exam Eligibility Pathway III.

The Council believes that the proposed changes to the first paragraph of the Criteria for Recognition of a Certification Board for Dental Assistants (Worksheet 4041, Lines 2-6) are necessary to conform to the ADA Governance and Organizational Manual and to be consistent with the same proposed revisions to the Criteria for Recognition of a Certification Board for Dental Laboratory Technicians (Resolution 67, Worksheet 4044, Lines 2-6.). Editorial changes replacing the term "prescribed" with the term "applied" to better describe the Council's role (Worksheet 4041, Line 13) and replacing the term "approval" with the term "recognition" (Worksheet 4041, Line 14) to better align with the document's title and intent also are recommended. Finally, the Council recommends adding language establishing and maintaining documented policies under "II. Operation of Board," Item 3, (Worksheet 4042, Lines 2-7) to ensure that the Certification Board follows best practices related to record keeping and examination validity and reliability and to be consistent with the proposed "IV. Standards" section of the Criteria for Recognition of a Certification Board for Dental Laboratory Technicians (Resolution 67, Worksheet 4044, Lines 45-47 and Worksheet 4045, Lines 1-2).

Accordingly, the Council on Dental Education and Licensure recommends adoption of the following resolution:

**Resolution**

**66. Resolved**, that the ADA Policy on Criteria for Recognition of a Certification Board for Dental Assistants (*Trans.* 1989:520; 2014:460) be amended as follows (additions underscored; deletions ~~stricken~~):

## Criteria for Recognition of a Certification Board for Dental Assistants

**Introduction:** An area of subject matter responsibility ~~of the Council on Dental Education and Licensure as indicated in the Governance and Operational Manual Bylaws of the American Dental Association is certifying boards and credentialing of allied dental personnel. The Council to studies and makes recommendations on policy related to the approval or disapproval of national certifying boards for allied dental personnel (each of which is referred to herein after as "the Board").~~

A mechanism should be made available for providing evidence that a dental assistant has acquired the knowledge and ability that is expected of an individual employed as a dental assistant through a program of certification. Such a certification program should be based on the educational requirements for dental assistants approved by the Commission on Dental Accreditation.

The dental profession is committed to assuring appropriate education and training of all personnel who participate in the provision of oral health care to the public. The following basic requirements are ~~prescribed~~ applied by the Council on Dental Education and Licensure for the evaluation of an agency which seeks ~~approval~~ recognition of the American Dental Association for a program to certify dental assistants ~~that reflects on the basis of~~ educational standards approved by the dental profession.

### I. Organization

1. The Board shall have no less than five nor more than nine voting members designated on a rotating ~~gen~~ basis in accordance with a method approved by the Council on Dental Education and Licensure. The following organizations/interests shall be represented on the Board:

- a. American Dental Assistants Association
- b. American Dental Association
- c. American Dental Education Association
- d. American Association of Dental Boards
- e. Public
- f. The at-large population of Board Certificants

All dental assistant members shall be currently certified by the Board.

2. The Board shall submit to the Council on Dental Education and Licensure evidence of adequate financial support to conduct its program of certification.

3. The Board may select suitable consultants or agencies to assist in its operations, such as the preparation and administration of examinations and the evaluation of records and examinations of candidates. Dental assistant consultants should be certified by the Board.

4. The Board shall submit in writing to the Council on Dental Education and Licensure a program sufficiently comprehensive in scope to meet the requirements established by the American Dental Association for the operation of a certifying board for dental assistants. This statement should include evidence that the Board has the support of the American Dental Assistants Association, the organization representative of dental assistants, as well as other groups within the communities of interest represented by the Board.

### II. Operation of Board

1. The Board shall grant certification to individuals who have provided evidence of knowledge-based competence in dental assisting.

2. The Board shall submit in writing to the Council on Dental Education and Licensure a plan for renewal of certificate currently held by certified persons.

3. The Board shall submit annually to the Council on Dental Education and Licensure data relative to its financial operations, applicant eligibility criteria, examination procedures and pass/fail results of its certifying examination. The Certification Board must establish and maintain documented policies concerning current, prospective and lapsed certificants including, but not limited to: eligibility, application, assessments, certification renewals and appeals. Additionally, the Certification Board must establish, analyze, publish and review examination content outlines which lay the foundation for the knowledge and skills tested on the assessment instruments and provide evidence of validity and reliability.

4. The Board shall administer the certification examinations at least twice each calendar year with administrations publicized at least six months prior to the examination.

5. The Board shall maintain and make available a current list of all persons certified.

6. The Board shall have authority to conduct the certification program; i.e., the Board shall be responsible for evaluating qualifications and competencies of persons certified and for maintaining adequate standards for the annual renewal of certificates. However, proposals for important changes in the examination eligibility criteria or the Board procedures and policies must be circulated reasonably well in advance of consideration to affected communities of interest for review and comment. Proposed changes must have the approval of the Council on Dental Education and Licensure.

7. The Board shall maintain close liaison with the organizations represented on the Board. The Board shall report on its program annually to the organizations represented on the Board.

### III. Granting Certificates

1. In the evaluation of its candidates for certification, the Board shall use standards of education and clinical experience approved by the Commission on Dental Accreditation. The Board shall require for eligibility for certification the successful completion of a dental assisting education program accredited by the Commission on Dental Accreditation, and satisfactory performance on an examination prescribed by the Board.

2. The Board shall grant certification or recertification annually to those who qualify for certification. The Board may require an annual certificate renewal fee to enable it to carry on its program.

### IV. Waivers

It is a basic view of the Council that all persons seeking certification shall qualify for certification by completing satisfactorily a minimum period of approved training and experience and by passing an examination. However, the Council realizes that there may be need for a provision to recognize candidates who do not meet the established eligibility criteria on educational training. Therefore, the Board may make formal requests to the Council on Dental Education and Licensure regarding specific types of waivers which it believes essential for certification and/or certificate renewal. Such requests shall be substantiated and justified to and supported by the organizations represented on the Board; only waivers approved by the Council on Dental Education and Licensure may be used.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 67 NewReport: N/A Date Submitted: July 2019Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None

Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_

Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

## 1 **AMENDMENT OF POLICY: CRITERIA FOR RECOGNITION OF A CERTIFICATION BOARD FOR** 2 **DENTAL LABORATORY TECHNICIANS**

3 **Background:** In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.*  
4 2012:370), the Council on Dental Education and Licensure has reviewed the policy, Criteria for  
5 Recognition of a Certification Board for Dental Laboratory Technicians for accuracy and currency. In  
6 doing so, the Council sought input from the ADA recognized certification board, the National Board for  
7 Certification in Dental Laboratory Technology (*Trans.*2002:400; 2014:460).

8 The Council believes that the proposed changes to the first paragraph of the Criteria for Recognition of a  
9 Certification Board for Dental Laboratory Technicians (Worksheet 4044, Lines 2-6) are necessary to  
10 conform to the *ADA Governance and Organizational Manual* and be consistent with the same language  
11 proposed in the Criteria for Recognition of a Certification Board for Dental Assistants (Resolution 66,  
12 Worksheet 4041, Lines 2-6). The Council also recommends an editorial change replacing the term  
13 "prescribed" with the term "applied" (Worksheet 4044, Line 11) to better describe the Council's role.  
14 Further, replacing the term "approval" with the term "recognition" (Worksheet 4044, Line 12) will better  
15 align with the document's title and intent. These changes are consistent with the same proposed changes  
16 to the Criteria for Recognition of a Certification Board for Dental Assistants. Finally, the Council  
17 recommends the proposed addition of the "IV. Standards" paragraph (Worksheet 4044, Lines 45-47 and  
18 Worksheet 4045, Lines 1-2) to ensure that the Certification Board follows best practices related to record  
19 keeping and examination validity and reliability and again to complement the same intent proposed under  
20 the paragraph titled, "2. Operation of the Board" of the Criteria for Recognition of a Certification Board for  
21 Dental Assistants (Resolution 66, Worksheet 4042, Lines 2-7).

22 Accordingly, the Council on Dental Education and Licensure recommends adoption of the following  
23 resolution:

### 24 **Resolution**

25  
26  
27 **67. Resolved**, that the ADA Policy on Criteria for Recognition of a Certification Board for  
28 Dental Laboratory Technicians (*Trans.*1989:520; 2014:460) be amended as follows  
29 (additions underscored; deletions ~~stricken~~):

## Criteria for Recognition of a Certification Board for Dental Laboratory Technicians

An area of subject matter responsibility ~~duty~~ of the Council on Dental Education and Licensure as indicated in the Governance and Operational Manual Bylaws of the American Dental Association is certifying boards and credentialing of allied dental personnel. The Council ~~to study~~ and makes recommendations on policy related to the approval or disapproval of national certifying boards for allied dental personnel (each of which is referred to herein after as "the Board").

A mechanism for the examination and certification of dental laboratory technicians is necessary to provide the dental profession with an indication of those persons who have demonstrated their ability to fulfill the dental laboratory work authorization. Such a certification program should be based on the educational requirements for dental laboratory technicians approved by the Commission on Dental Accreditation.

The following basic requirements are applied ~~prescribed~~ by the Council on Dental Education and Licensure for the evaluation of an agency which seeks recognition ~~approval~~ of the American Dental Association for a program to certify dental laboratory technicians on the basis of educational standards approved by the dental profession.

**I. Organization:** An agency that seeks approval as a Certification Board for Dental Laboratory Technicians should be representative of or affiliated with a national organization of the dental laboratory industry and have authority to speak officially for that organization. It is required that each dental laboratory technician member of the Certification Board hold a certificate in one of the areas of the dental laboratory technology.

**II. Authority and Purpose:** The rules and regulations established by the Certification Board of Dental Laboratory Technicians will be considered for approval by the Council on Dental Education and Licensure on the basis of these requirements. Changes that are planned in the rules and regulations of the Certification Board should be reported to the Council before they are put into effect. The Board shall submit data annually to the Council on Dental Education and Licensure relative to its financial operations, applicant admission and examination procedures, and results thereof.

The principal functions of the Certification Board shall be:

- a. to determine the levels of education and experience of candidates applying for certification examination within the requirements for education established by the Commission on Dental Accreditation;
- b. to prepare and administer comprehensive examinations to determine the qualifications of those persons who apply for certification; and
- c. to issue certificates to those persons who qualify for certification and to prepare and maintain a roster of certificants.

**III. Qualifications of Candidates:** It will be expected that the minimum requirements established by the Certification Board for the issuance of a certificate will include the following:

- a. satisfactory legal and ethical standing in the dental laboratory industry;
- b. graduation from high school or an equivalent acceptable to the Certification Board;
- c. a period of study and training as outlined in the Accreditation Standards for Dental Laboratory Technology Education Programs, plus an additional period of at least two years of working experience as a dental laboratory technician; or, five years of education and/or experience in dental technology; and
- d. satisfactory performance on examination(s) prescribed by the Certification Board.

**IV. Standards:** The Certification Board must establish and maintain documented policies concerning current, prospective and lapsed certificants including, but not limited to: eligibility, application, assessments, certification renewals and appeals. Additionally, the Certification Board must establish,

analyze, publish and review examination content outlines which lay the foundation for the knowledge and skills tested on the assessment instruments and provide evidence of validity and reliability.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 68 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Dental Education and Licensure

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

## 1 **RESCIND POLICY ON ADMISSIONS CRITERIA FOR DENTAL HYGIENE PROGRAMS**

2 **Background:** In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.*  
3 2012:370), the Council on Dental Education and Licensure has reviewed the policy, Admissions Criteria  
4 for Dental Hygiene Programs, and believes that this statement is no longer necessary as admission  
5 criteria and procedures, previous academic performance and/or performance on standardized national  
6 scholastic tests are specifically addressed in Standard 2-3 of the CODA Accreditation Standards for  
7 Dental Hygiene Education Programs which states:

8  
9 Admission of students must be based on specific written criteria, procedures and policies.  
10 Previous academic performance and/or performance on standardized national tests of  
11 scholastic aptitude or other predictors of scholastic aptitude and ability must be utilized as  
12 criteria in selecting students who have the potential for successfully completing the program.  
13 Applicants must be informed of the criteria and procedures for selection, goals of the  
14 program, curricular content, course transferability and the scope of practice of and  
15 employment opportunities for dental hygienists.

16  
17 Accordingly, the Council recommends that the House rescind the policy statement on admissions criteria  
18 for dental hygiene programs.

### 19 **Resolution**

20  
21  
22 **68. Resolved,** that the ADA Policy on Admissions Criteria for Dental Hygiene Programs  
23 (*Trans.*1995:639) be rescinded.

24  
25 **BOARD RECOMMENDATION: Vote Yes.**

26  
27 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**  
28 **BOARD DISCUSSION)**

**WORKSHEET ADDENDUM**  
**POLICY TO BE RESCINDED**

**Policy on Admissions Criteria for Dental Hygiene Programs (*Trans.*1995:639)**

**Resolved**, that the American Dental Association supports the admission of students into dental hygiene education programs based on established criteria and procedures, and be it further

**Resolved**, that previous academic performance and/or performance on standardized national scholastic tests will be utilized as primary criteria in selecting students.

Resolution No. 69 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Dental Education and Licensure

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

## 1 **RESPONSE TO RESOLUTION 83-2018: GERIATRIC DENTISTRY**

2 **Background:** The 2018 House of Delegates considered Resolution 83-2018, which was referred to the  
3 Council on Dental Education and Licensure (CDEL) for further study and report to the 2019 House of  
4 Delegates:

5  
6 **83-2018. Resolved,** that the Council on Dental Education and Licensure (CDEL) explore, with  
7 other appropriate communities of interest, the feasibility of requesting the development of an  
8 accreditation process and accreditation standards for advanced education programs in geriatric  
9 dentistry by the Commission on Dental Accreditation. The feasibility study is to be provided to the  
10 2019 House of Delegates.

11  
12 *\*The following provisions were offered for consideration during debate on referral:*

13  
14 *In recognition of the expanding population in need of geriatric care, it is requested that*  
15 *the report to the 2019 House of Delegate address the following actionable strategies for*  
16 *both hygienists and dentists with respect to the following points:*

- 17  
18 1. *To enhance and expand pre-doctoral training.*  
19 2. *To develop and promote continuing education programs for existing practitioners*  
20 3. *To investigate advanced educational opportunities.*

21  
22 *All with the goal of increasing access to competent and broadly available geriatric care in*  
23 *all oral healthcare settings both public and private.*

24  
25 In considering referred Resolution 83-2018, the Council conducted an electronic survey, Survey on  
26 Feasibility of Accreditation for Geriatric Dentistry Residency Programs, of the appropriate communities of  
27 interest to gather information and clarify the interest and understanding of the geriatric dentistry practice  
28 and education communities in developing an accreditation process and standards for advanced education  
29 programs in geriatric dentistry.

30 The results of the Survey on Feasibility of Accreditation for Geriatric Dentistry Residency Programs  
31 are presented in Appendix 1. In regard to Question 9, 44.4% of the respondents indicated  
32 awareness of an association/organization/entity that may be interested in leading the pursuit of  
33 Commission on Dental Accreditation (CODA)-accreditation for geriatric dentistry programs. Those

1 responding most often cited the Special Care Dentistry Association as the organization that may be  
2 interested in taking the lead.

3 Various resources were used to provide the Council with pertinent data such as Geriatric Dentistry  
4 Program and Enrollment Data 2011-2018, excerpts of CODA Accreditation Standards Referencing  
5 "Geriatrics/Older Adults/Seniors/Elderly/Special Needs/All Stages of Life," and excerpts of the 2018-2019  
6 Curriculum Survey of Dental Education Programs (DDS/DMD) with tables representing the first time  
7 collection of data related to experiences of predoctoral students with geriatric dentistry patient  
8 populations.

9 The Council considered the criteria outlined in the CODA's *Policies and Procedures for*  
10 *Accreditation of Programs in Areas of Advanced Dental Education* that provide a framework for the  
11 Commission in determining whether a process of accreditation review should be initiated for  
12 advanced dental education programs, as noted below:

- 13 A. A well-defined body of established scientific dental knowledge exists that underlies the advanced  
14 dental education area – knowledge that is in large part distinct from, or more detailed than, that of  
15 other dental education areas already in accreditation review.
- 16 B. The body of knowledge is sufficient to educate individuals in a distinct advanced dental education  
17 area, not merely one or more techniques.
- 18 C. A sufficient number of established programs exist and contain structured curricula, qualified  
19 faculty and enrolled individuals so that accreditation can be a viable method of quality assurance.
- 20 D. The education programs are the equivalent of at least one twelve-month full-time academic year  
21 in length. The programs must be academic programs sponsored by an institution accredited by  
22 an agency recognized by the United States Department of Education or accredited by an  
23 accreditation organization recognized by the Centers for Medicare and Medicaid Services (CMS)  
24 rather than a series of continuing education experiences.
- 25 E. Other evidence that the programs are bona fide higher education experiences, rather than a  
26 series of continuing education courses (e.g. academic calendars, schedule of classes, and syllabi  
27 that address scope, depth and complexity of the higher education experience, formal approval or  
28 acknowledgment by the parent institution that the courses or curricula in the education area meet  
29 the institution's academic requirements for advanced education). The quality of the advanced  
30 dental educational program is important to the health care of the general public.

31 It should be noted that in 2015 the Special Care Dentistry Association pursued accreditation by CODA for  
32 advanced general dentistry education programs in special care dentistry. At its February 2016 meeting,  
33 the Commission determined that the application requesting accreditation for these programs did not  
34 adequately address the CODA criteria for initiating an accreditation process for advanced education  
35 programs in a new area; the Commission was unable to confirm that Criteria A – E were met and directed  
36 that a process of accreditation for advanced general dentistry education programs in special care  
37 dentistry not be established at that time.

38 CDEL Chair, Dr. Rekha Gehani and CDEL Vice chair, Dr. Linda Niessen, also sought input from the  
39 National Elder Care Advisory Committee (NECAC). Members of the NECAC supported the  
40 development of an accreditation process and Accreditation Standards for Advanced Education  
41 Programs in Geriatric Dentistry and discussed the possibility of including standards related to  
42 treating "special needs patients." The Council discussed NECAC's suggestion to include the  
43 terminology "special needs patients" in addition to "geriatric dentistry." However, the Council  
44 concluded that because Resolution 83 specifically addressed the feasibility of requesting the  
45 development of an accreditation process and accreditation standards for advanced education

programs in geriatric dentistry, the response to the House of Delegates should remain focused on the accreditation of geriatric dentistry programs.

In addition, Dr. Rekha Gehani and Dr. Linda Niessen met with the faculty (experts in the field of geriatric dentistry) presenting the Geriatric Symposium held at ADA Headquarters on June 28, 2019 to gain their perspective and/or interest in accreditation of geriatric dentistry residency programs.

Finally, the Council reviewed the additional provisions that were offered for consideration during debate of referral of Resolution 83 but were not acted upon by the House (Worksheet 4048, Lines 12-23). The Council received excerpts of geriatric-related instructional content and patient experiences noted in Accreditation Standards for Dental Education Programs, the Accreditation Standards for advanced dental education programs in general practice residency, general dentistry, dental anesthesiology, dental public health, endodontics, oral and maxillofacial surgery, oral and maxillofacial pathology, oral and maxillofacial radiology, oral medicine, orofacial pain, orthodontics and dentofacial orthopedics, periodontics, and prosthodontics and the accreditation standards for dental hygiene education programs and dental therapy education programs referencing terms such as "Geriatrics," "Older Adults," "Seniors," "Elderly," "Special Needs," and "All Stages of Life," concluding that the requirements are appropriate. The Council also reviewed a list of continuing education courses on the subject of elder care/geriatrics offered during the past three ADA Meetings and a list of continuing education online courses currently offered on the subject of Elder Care/Geriatrics (Appendix 2). Words and phrases in Appendix 2 referencing geriatrics, the elderly, and special care/needs patients are highlighted for easy reference.

**Summary:** While it appears to the Council that it would be feasible for advanced education programs in geriatric dentistry to seek accreditation and that the education community - including the Special Care Dentistry Association - are supportive, it is not clear if an application to CODA requesting accreditation for geriatric dentistry programs can meet the CODA criteria to begin the process. Nonetheless, the Council recommends that the House of Delegates provide the preliminary findings presented in this report to the Special Care Dentistry Association for consideration and possible pursuit of seeking an accreditation process for these programs.

## Resolution

**69. Resolved,** that the findings of the feasibility study conducted by the Council on Dental Education and Licensure be provided to the Special Care Dentistry Association for its consideration in pursuing an accreditation process and accreditation standards for advanced education programs in geriatric dentistry by the Commission on Dental Accreditation.

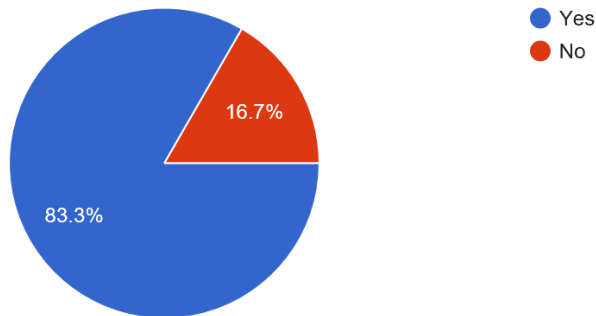
## BOARD RECOMMENDATION: Vote Yes.

### Vote: Resolution 69

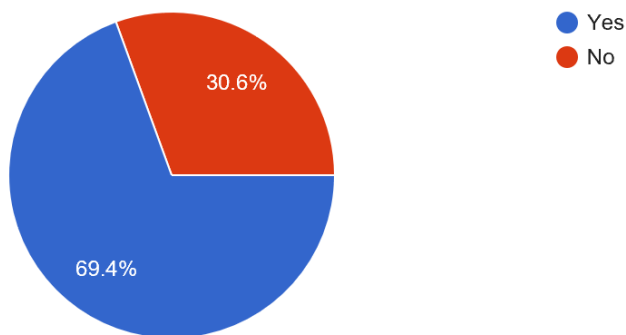
BLACK	Yes	GEHANI	Yes	KLEMMEDSON	Yes	RODRIGUEZ	Absent
COHLMIA	Yes	HARRINGTON	Yes	KYGER	Yes	SABATES	Yes
DOROSHOW	Yes	HERRE	Yes	LEARY	Yes	SHEPLEY	Yes
EDGAR	Yes	HIMMELBERGER	Yes	MCDUGALL	Yes	STEPHENS	Yes
FISCH	Yes	HUOT	No	NORBO	Yes	THOMPSON	No

**ADA Council on Dental Education and Licensure**  
**Survey on Feasibility of Accreditation for Geriatric Dentistry Residency Programs**

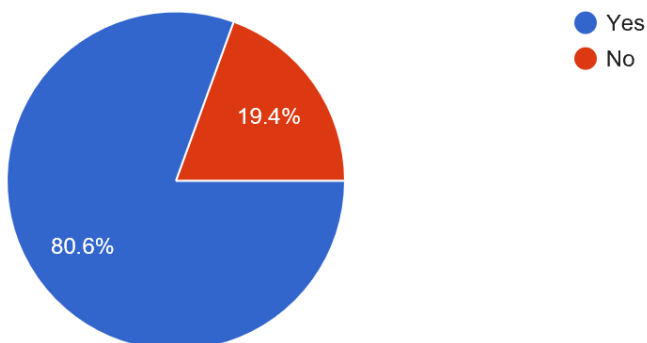
1. Do you believe that a well-defined body of established scientific dental knowledge exists and supports advanced education programs in geriatric dentistry?



2. Is this knowledge in large part distinct from, or more detailed than, that of other advanced education programs already accredited by CODA (for example, general practice residencies, advanced education in general dentistry programs, prosthodontics programs)?



3. Is the scope and depth of this body of knowledge sufficient to educate individuals in geriatric dentistry and not merely one or more techniques?



## 4. To your knowledge, how many geriatric dentistry programs exist?

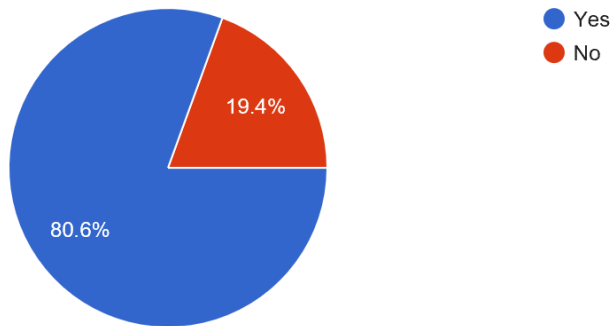
12
0
6
I don't know
7
16
18
unknown
6
4-Mar
6
none of any consistent value
None
10-Jun
12
0
5
Just a couple
5
6
4
5
15-20
My understanding is that only 6 accept applications
8
3
1
5
Unknown; speculate very few to none
3
I do not know the number but along with our aging demographics, I see a growing interest and increase in the number of continuing education opportunities.
4 programs that I know of.
5
3 that offer an extended program with a certificate or degree upon completion
9
5

## 5. Please list their sponsoring institutions (e.g., accredited universities or hospitals) and locations.

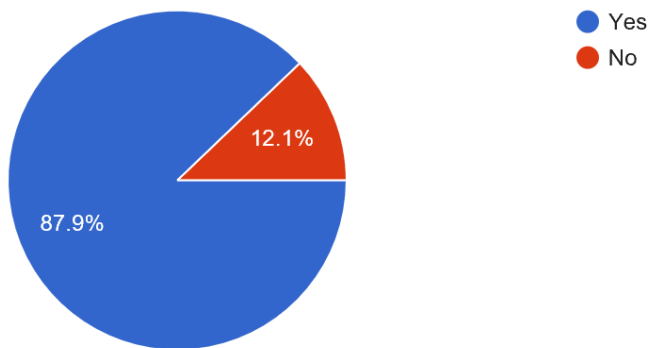
Boston University, Minnesota, Harvard, Rochester, Iowa, USC, Penn, Duke, John Hopkins, Mt Sinai, Drew, North Texas U, U Texas at San Antonio, USC LA, Las Vegas U
n/a
Boston University, University of Iowa, University of Minnesota, University of Rochester, Harvard University, University of Southern California
I don't know
Harvard, University of Maryland, USC, UCLA, University of Iowa, Ohio State, Duke, University of Louisville

Univ of Minnesota, Minneapolis, MN; Univ of Rochester, Rochester, NY; Harvard Univ, Boston, MA; Univ of Iowa, Iowa City, IO; Univ of Southern California, Los Angeles, CA; Boston Univ, Boston, MA
See: <a href="http://www.jdentaled.org/content/81/10/1220">http://www.jdentaled.org/content/81/10/1220</a>
unknown
6
don't know
University of Minnesota, University of Rochester, Harvard University, University of Iowa, University of Southern California, Boston University
none
N/A
UT San Antonio
Harvard, BU, Maryland, Rochester, USC, Minnesota, Rutgers, Univ Penn, UCLA, San Antonio, Iowa, Mt. Sinai
0
University of Iowa, University of Rochester (New York), USC (California), Boston University, Harvard
Duke University, USCF, UCLA and Harvard
University of Iowa, Boston University, Harvard University, UCSF, UCLA
Iowa, Boston Univ, USC, Rutgers, Washington, u of Pacific, one more?
xx
University of Iowa USC Rochester Boston
USC, Duke, Harvard, Ohio State, Louisville
Uncertain of complete program list
University of Iowa; University of Minnesota, Harvard University; University of South California; University of California at San Francisco; Boston University; University of California at Los Angeles; Duke University
university
Iowa
Boston Univ.; Harvard; University of Iowa; University of Minnesota; University of Southern California
unknown
Boston Univ., Harvard, University of Iowa, University of Minnesota and the University of Southern California
The University. of Minnesota has a mini-residency in geriatric dentistry.
University of Iowa, University of Southern California, University of Minnesota, Eastern Institute of Oral Health.
Iowa, USC (online), Harvard (didactic mostly), ??
USC, Iowa, Harvard
Harvard School of Dental Medicine, Boston University, University of Minnesota School of Dentistry, University of Iowa College of Dentistry, Eastman Dental Center Rochester NY, University of Southern California, University of California San Francisco, University of Florida, University of Connecticut School of Dentistry
Herman Ostrow School of Dentistry of the University of Southern California; Harvard University; University of Iowa; Boston University; University of Rochester

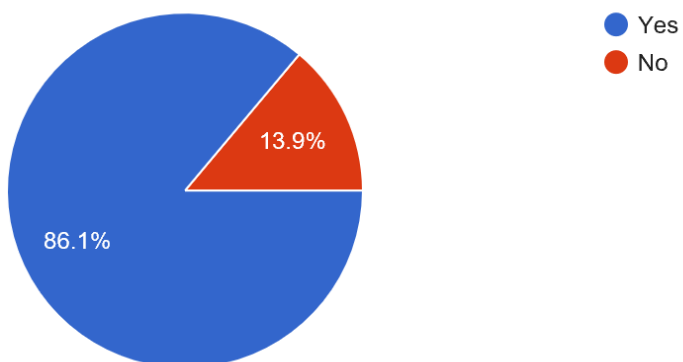
6. Do they contain structured curricula, qualified faculty and residents making accreditation a viable method of quality assurance?



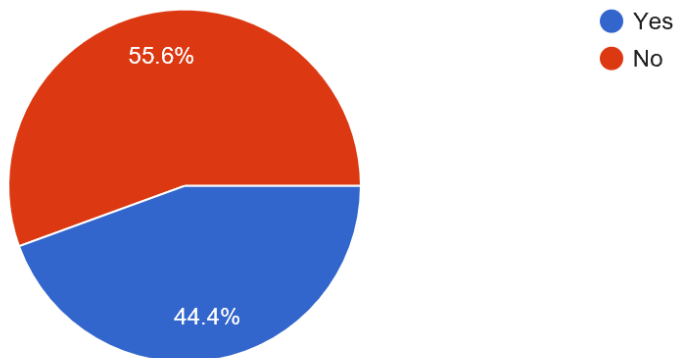
7. If yes, are these geriatric dentistry programs at least one 12-month full-time academic year in length?



8. Do they grant certificates or degrees to residents upon completion?



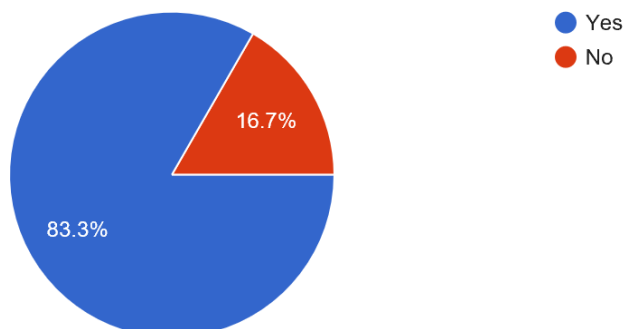
9. Are you aware of an association/organization/entity that may be interested in leading the pursuit of CODA-accreditation for geriatric dentistry programs?



If yes, please explain:

Special Care Dentistry
Special Care Dentistry Association - SCDA
Special Care Dentistry
Special care in Dentistry Association
Special Care Dentistry Association
Special Care in Dentistry Association
The Geriatrics Council of the Special Care Dentistry Association
SCDA - but only if it is called "Geriatrics and Special Care Dentistry"
I would hope the Geriatric Dentistry section of SCD would take the lead
Special Care Dentistry Association
Council on Geriatric Dentistry (part of the Special Care Dentistry Association)
Special Care Dentistry Assoc.
ADEA section on geriatrics and gerontology, Special Care Dentistry
Special Care Dentistry - American Society of Geriatric Dentistry

10. Do you think that dental care for older adults will benefit by having an accredited advanced education program in geriatric dentistry?



If yes, please explain.

Provide an in depth integration of medicine, pharmacology, and behavioral sciences and dentistry
I believe that a geriatric dentistry program should be expanded to include adult disabled and special needs since the majority of disabilities occur after 65.
It might allow for a large number of highly trained dental workforce to treat the growing number of frail older adults in alternative care settings
It will train Geriatric dentists that will focus on providing care for older patients with specific needs that general dentists can't or don't know how to treat
Many general practitioners are not comfortable treating medically compromised geriatric patients. These programs would provide practitioners specifically trained to treat these patients who are growing in number with every passing day. Also, this proposal does not suggest that every geriatric patient will go to a geriatric dentist just as not every pediatric patient goes to a pediatric dentist.
Probably would support wider understanding of and interest in this area of gen den
Advanced level of knowledge of the graduates to treat more complicated patients and provide an appropriate level of care.
Enhanced understanding of oral health challenges (local and systemic).
It gives legitimacy to those teaching in Universities, and in Long term care
Education is always to the benefit and could also lead to research to enhance care
Older adults can have a combination of complex medical histories due to the progression of chronic diseases and have complex dental needs. Teeth have generally been filled multiple times over their life and a decline in general health can cause a unplanned decline in dental health. Treating these patients takes a different philosophy focusing on quality of life. Dental schools have a limited time to teach ideal treatment planning and dental care let alone a different philosophy needed for older adults. Thus geriatric dentistry can be better taught in advanced education. GPRs and AEGDs are generally confined to a hospital setting allowing experiences treating adults with select medical conditions or allow treatment under general anesthesia allowing ideal working conditions. Thus GPRs and AEGDs somewhat touch on geriatric dentistry, but it is not their primary focus. With increasing numbers of elderly patients, increasing complexity, increased risk of oral disease, and increased demand for dental care, I believe it is time for geriatric dentistry programs to be accredited so future dentists are adequately prepared for the task of treating older adults.
There is a whole different set of skills that you need to pull together in order to treat elderly patients. Since 25% of the US population soon will be 65+ and need extra attention for their dental care, I believe that there is a huge benefit in creating accredited geriatric dentistry programs in order to secure quality of care.
Fosters financial support for education, encourages research. It works in Europe.
There is a body of knowledge, skills and attitude in Geriatrics and Special Care
The care of medically, functionally and cognitively compromised adults is a critical challenge now and will only get worse with an increasing older population. The medical, physical and pharmaceutical challenges with this population is beyond the scope of the GP in many cases, especially those residing in long term care facilities. A cohort of trained Geriatric dentists is essential to meet this demand and provide adequate access to care.
With an aging population and the complexity of aging and medication, accredited program are very much need.
I believe that it is important to train dentist to be competent in treating the large, growing, diverse segment of the geriatric population, including managing the medical complexities this involves
the complex medical history, polypharmacy, cognitive impairment and functional disability can substantially compromise oral health, which in turn can lead to serious systemic complications. This two way relationship should be carefully incorporated into clinical treatment planning for geriatric patients to achieve desired treatment outcome

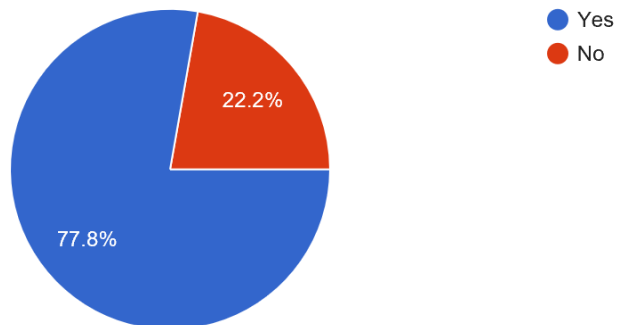
I think additional education in this area will benefit any practitioner but I am dubious it should be a separate program given that all dentists will be treating geriatric patients. We should be focusing this type of education in dental schools, not residencies.
Older adults have more extensive health issues and corresponding pharmacy issues. It would be focusing on a segment of the population similar to pediatric dentistry. Just as those who provide care to children have special training those who provide care to older adults should have the equivalent.
With the growing population of older adults, geriatric specialists are needed to distinguish best practices in all aspects of health care. Dentistry is lagging behind, so more is needed.
Both in terms of increased access to specialty care, I think that an advanced education program will provide support to general practitioners much as pediatric dentists support general dentists and dental hygienists. I also think that a specialty will help increase inter-professional practice.
Maybe
To the extent these programs train future educators who can then train future general practitioners and other dental specialists about the needs of this population as well as carry out relevant research and advocacy, I think this could be very beneficial. If this can provide some means or argument to make these programs sustainable in the long term that is needed. It seems unlikely that even with such programs, there would be enough of these providers to care for the entire geriatric population and we should take care that general providers are not then dissuaded from treating older adults, across the spectrum of dependence nor that they default to saying older adults with any complexity must be treated by someone with such certification. If this were the perception, this could end up being a disservice.
Treatment of older adults requires specific knowledge among others on biology, physiology and psychology of aging and their effects on an individual. Moreover knowledge about specific chronic diseases common in older adults, medications their impact on oral health and necessary dental management modifications when caring for older adults. These are just a few aspects to name.
By 2030, projections show that 1 in every 5 residents will be age 65 and older and by 2035 residents 65 years of age and older will for the first time out number the population of children living in the United States (U.S. Census CB18.41). We are already appreciating these increases in the older adult population with more and more older adults seeking dental care than ever before. Nor is it just the volume of patients that is concerning but the fact that, just as with children, the older adult demonstrates unique physiologic and pathologic findings and demonstrates increasing instances and presentations of oral diseases and oral manifestations of systemic diseases rarely seen in the average adult or middle aged dental patient. Findings of multiple co-morbidities, physical frailties, and cognitive disturbances often further complicate the presentation of an older adult patient. The recognition of these multitudes of conditions, the understanding of underlying physiologic and pathologic disease processes, the ability to collaborate with the patient's entire health care team, contributing to the overall management plan, and to incorporate thoughtful consideration of the patient's unique presentation, in collaboration with the patient and his/her family, are the keys that will allow a practitioner to deliver the most appropriate care utilizing necessary treatment modifications. To achieve this goal we must provide an in-depth educational opportunity that is available to as many dentists as possible, thus equipping them to appropriately care for older adults in their practice environments.

If no, please explain.

I am glad that there are programs for dentists who wish to pursue advanced education in Geriatrics and Special Needs patients. However, there will never be enough dentists who wish to pursue this educational pathway to take care of the current aging population. A better way to improve Geriatric care, in my opinion, would be to include quality education in Geriatrics/Special Needs in dental school and offer more advanced continuing education courses for currently practicing dentists who wish to pursue caring for this population in their practices or expand their practices to nursing home, home bound, etc.
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There is not an adequate scientific database and set of special skills requiring CODA accreditation.
There are far too many seniors to limit access to specialize geriatric care
The worry is that there are practices where dentists age into being a practice for older adults, especially prosthodontists and periodontist ms. How does this remain compatible.

11. Do you believe that existing geriatric dentistry programs would be interested in pursuing accreditation by the Commission on Dental Accreditation?



Why?

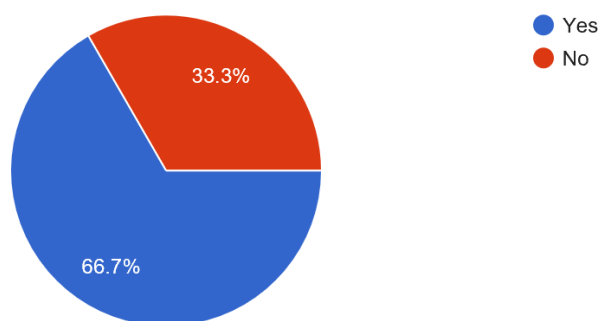
Very important to have a highly trained geriatrician-dental to be able to communicate with medical colleagues and provide excellent patient care. Patients are the real winners. With the senior population increasing at an accelerated rate, that aged will be over 25% of the population.
Don't know of any
Accreditation by the Commission on Dental Accreditation would probably increase their candidates pool
Because it's important to have solid educational programs that follow the CODA standards
I can't say with certainty, however, this proposal was being pursued some 10-12 years ago, but federal government funding at the time was severely cut for graduate programs, effectively terminating the process before it picked up steam.
unsure and do not feel qualified to answer the question+
Standardized the program to other accredited programs
Elevation of standards of educational process formally.
To give legitimacy to their programs
That is the push behind this survey, I assume
status
I would like to see the geriatric dentistry programs focused on accomplishing the same goals and standards with a focus on patient care.
Job positions might soon require a certified Geriatric Dentist from an accredited program.
Financial support
Again, much more likely if it was "Geriatric AND Special Care Dentistry"
To give legitimacy to what they know is needed. It will also make it easier to attract qualified (and interested) students. And get GME money.
Thanks to AAID and court cases the public has no idea who has accredited specialty education.
It is important to legitimize the fellowship training
If the existing programs could be accredited by ADA, these programs would receive more attention, support and resources from their institutes. They would also be able to attract more students to attend the fellowship programs.
It may help the programs advertise and create awareness for their programs.

Not really sure without involving them in the discussion. Maybe isn't an option on this survey. I would not say no without furthering the discussion.
It will strengthen their effort
To further legitimize the practice of geriatric dentistry
To attract students.
credibility
I have no way of knowing this but I was forced to answer the question.
Over the years these discussions have ensued among the academics involved in these programs. Interested students regularly ask if these programs are accredited.

Why not?

In my opinion, the current programs probably think they are doing what they think is best and functioning well without having to have the added burden of making sure they are CODA accredited. However, I have not actual knowledge of how they feel.
It would only add financial burden to the program and stifle innovation by requiring adherence to a set of standards.
There is not consistency in the instruction and quality of efforts
Just a guess but would it be worth the effort and would it improve the program. Would it attract more applicants?
I cannot see any reason why not!
Most of these programs are within universities with an Oral Medicine established programs and is considered as adjunct training to my knowledge

12. Do you believe that an accredited advanced education program in geriatric dentistry will increase access to care?



Why?

Provide a greater comfort level for dentist to treat medically complex seniors allowing for greater access to care. With seniors comprising such a high percent of our population, comfort in treating and providing rational treatment planning, will encourage dentists to seek out this population. Win-win situation.
We need more dentists educated in the care of the disabled and frail older adult and an expansion of long term facility care.
Because it might increase the number of highly trained dentists in geriatrics
Because more trained Geriatric dentists will provide better care to an increasing number of older adults
Geriatric patients who cannot, or won't, be treated by general practitioners now have another option to see a specialist who is trained to treat that group of patients.
Potentially by raising the standard and visibility of the discipline

Accreditation may provide GME/IME funded residency positions
Increased awareness and expansion of formally trained professionals.
It will provide more Teachers and Mentors
I don't think it would create a larger group of applicants.
I think accredited advanced education in geriatric dentistry is a step in the right direction to increase access to care, but I also think access to care would greatly improve with increased opportunities for dental benefits. So then what comes first the chicken (advanced education programs in geriatric dentistry to increase practitioners comfort and knowledge treating complex older adults) or the egg (increased dental benefits for older adults example: Medicare Dental Benefits).
It gives attention to the special oral and systemic conditions that accompanies aging; and shows the importance of training on the provider part.
More trainees
Yes, but more likely if it is a specialty on "Geriatrics and Special Care Dentistry"
More programs will result in more trained Geriatric dentists with the goal of "specializing" and maintaining a practice devoted to the geriatric patient. It might also result in better training of predoctoral students, as it will enhance an existing paltry pool of trained geriatric dentists to teach.
Hope it shines a lot on a forgot aspect of our population.
I am not sure that would correlate
Increasing in number of geriatric patients and the era of polypharmacy and all the effects on oral mucosa will need close monitoring of patients.
Does pediatric dentistry increase access to care? The barriers will be similar.
There will be more providers who specialize in this field available to the population
More practitioners will seek the specialty. This provides the opportunity for a greater coverage of the growing population.
As previously mentioned, I believe that it will create better prepared specialists who, in addition to treating their own patients, will be a resource to general practitioners to bolster their skills and willingness to treat older adults.
Accreditation of the field of geriatric dentistry provides recognition of the field and its unique body of knowledge to the public as well as the profession. Having more practitioners who can widely indicate that they have formal training in geriatric dentistry will attract more dentists interested in this training. Ultimately more dentists trained will result in more access to care.

Why not?

There will never be enough dentists who wish to pursue this career path to care for the aging population. We need every general dentist to feel comfortable treating the aged to make a difference with access to care.
Adding CODA approval to existing or future programs in geriatric dentistry would not increase access to care.
No impact. Patients would be better served by being treated by existing specialty dentists.
Within scope of general dentistry
supply and demand
Only if it makes some dentists refuse to see some older adults.
Access to care is affected by multiple issues, Accreditation of a geriatric dentistry program would not eliminate these obstacles
I don't think there will be enough programs to have a meaningful impact. The impact would be greater if the focus was on dental schools.
Only if graduates end up working in dental schools, to teach pre-doc students. This doesn't happen often.
Again, no choice about the answer here and this is a maybe. As long as reimbursement and the many other issues around access for this population are addressed, having more providers alone will have a limited impact on access and it seems unlikely enough providers would be generated to make a huge impact on the numbers of older adults who lack for oral health care.

Thank You for Participating!

Thank you, impressed to be asked and impressed that you care to investigate.
I believe we need an accredited advanced education program for the care of the adult disabled special needs patient and frail elders.
Construction of the survey forces answers to some questions that I do not have knowledge of. I worry that the quality of overall response will be negatively impacted.
My pleasure and thanks for your work.
The first many questions of this survey are a big problem because there is no option for "I don't know" and also because several appear to assume that my answer for Question #1 would be "yes" -- which it wasn't.

**Excerpts of CODA Accreditation Standards Referencing  
“Geriatrics/Older Adults/Seniors/Elderly/Special Needs/All Stages of Life”**

**Accreditation Standards for Dental Education Programs**

**2-23** Graduates **must** be competent in providing oral health care within the scope of general dentistry to patients in **all stages of life**

**2-24** At a minimum, graduates **must** be competent in providing oral health care within the scope of general dentistry, as defined by the school, including

- a. patient assessment, diagnosis, comprehensive treatment planning, prognosis, and informed consent;
- b. screening and risk assessment for head and neck cancer;
- c. recognizing the complexity of patient treatment and identifying when referral is indicated;
- d. health promotion and disease prevention;
- e. local anesthesia, and pain and anxiety control, including consideration of the impact of prescribing practices and substance use disorder;
- f. restoration of teeth;
- g. communicating and managing dental laboratory procedures in support of patient care;
- h. replacement of teeth including fixed, removable and dental implant prosthodontic therapies;
- i. periodontal therapy;
- j. pulpal therapy;
- k. oral mucosal and osseous disorders;
- l. hard and soft tissue surgery;
- m. dental emergencies;
- n. malocclusion and space management; and
- o. evaluation of the outcomes of treatment, recall strategies, and prognosis

**Intent:**

*Graduates should be able to evaluate, assess, and apply current and emerging science and technology. Graduates should possess the basic knowledge, skills, and values to practice dentistry, independently, at the time of graduation. The school identifies the competencies that will be included in the curriculum based on the school's goals, resources, accepted general practitioner responsibilities and other influencing factors. The comprehensive care experiences provided for patients by students should be adequate to ensure competency in all components of general dentistry practice. Programs should assess overall competency, not simply individual competencies in order to measure the graduate's readiness to enter the practice of general dentistry.*

**2-25** Graduates **must** be competent in assessing the treatment needs of patients with **special needs**.

**Intent:**

*An appropriate patient pool should be available to provide experiences that may include patients whose medical, physical, psychological, or social situations make it necessary to consider a wide range of assessment and care options. The assessment should emphasize the importance of non-dental considerations. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable **elderly**. Clinical instruction and experience with the patients with **special needs** should include instruction in proper communication techniques and assessing the treatment needs compatible with the special need.*

**Standards for Advanced Dental Education Programs****Accreditation Standards for Advanced Education Programs in General Practice Residency****Goals:**

1. Act as a primary care provider for individuals and groups of patients. This includes: providing emergency and multidisciplinary comprehensive oral health care; providing patient focused care that is coordinated by the general practitioner; and directing health promotion and disease prevention activities.
2. Plan and provide multidisciplinary oral health care for a wide variety of patients including patients with special needs.

**2-1.** The program **must** provide didactic and clinical training to ensure that upon completion of training, the resident is able to:

- b) Assess, diagnose, and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs.

**Accreditation Standards for Advanced Education Programs in General Dentistry**

The goals of these programs should include preparation of the graduate to: 1. Act as a primary care provider for individuals and groups of patients. This includes: providing emergency and multidisciplinary comprehensive oral health care; providing patient focused care that is coordinated by the general practitioner; and directing health promotion and disease prevention activities. 2. Plan and provide multidisciplinary oral health care for a wide variety of patients including patients with special needs.

**2.1** The program **must** provide didactic and clinical training to ensure upon completion of training, the resident is able to:

- b) Assess, diagnose and plan for the provision of multidisciplinary oral health care for a wide variety of patients including patients with special needs.

**Accreditation Standards for Advanced Dental Education Programs in Dental Anesthesiology**

**2-1** The program **must** list the written competency requirements that describe the intended outcomes of residents' education such that residents completing the program in dental anesthesiology receive training and experience in providing anesthesia care in the most comprehensive manner using pharmacologic and non-pharmacologic methods to manage anxiety and pain in adult and child dental patients, including patients with special needs.

***Intent:** The program is expected to develop specific competency statements that describe what the resident will be able to do upon completion of the program. These statements should describe the resident's abilities rather than educational experiences the residents may participate in. These competency statements are to be circulated to program faculty and staff and made available to applicants of the program.*

**2-2** Upon completion of training, the resident **must** be:

- a) Able to demonstrate in-depth knowledge of the anatomy and physiology of the human body and its response to the various pharmacologic agents used in anxiety and pain control;
- b) Able to demonstrate in-depth knowledge of the pathophysiology and clinical medicine related to disease of the human body and effects of various pharmacological agents used in anxiety and pain control when these conditions are present;
- c) Competent in evaluating, selecting and determining the potential response and risk associated with various forms of anxiety and pain control modalities based on patients' physiological and psychological factors;

**2-4** Didactic instruction at an advanced and in-depth level beyond that of the pre-doctoral dental curriculum **must** be provided and include:

- a) Applied biomedical sciences foundational to dental anesthesiology,

**Intent:** Instruction should include physiology, pharmacology, anatomy, biochemistry, pathology, physics, pathophysiology, and clinical medicine as it applies to anesthesiology. The instruction should be sufficiently broad to provide for a thorough understanding of the body processes related to anxiety and pain control. Instruction should also provide an understanding of the mechanisms of drug action and interaction, as well as information about the properties of drugs used.

b) Physical diagnosis and evaluation,

**Intent:** This instruction should include taking, recording and interpreting a complete medical history and physical examination, and understanding the indications for and interpretations of diagnostic procedures and laboratory studies.

c) Behavioral medicine,

**Intent:** This instruction should include psychological components of human behavior as related to the management of anxiety and pain.

**2-6** The following list represents the minimum clinical experiences that **must** be obtained by each resident in the program at the completion of training:

(3) Seventy five (75) patients with **special needs**,

b) Clinical experiences sufficient to meet the competency requirements (described in Standard 2-1 and 2-2) in managing ambulatory patients, geriatric patients, patients with physical status ASA III or greater, and patients requiring moderate sedation; and

**2-9** At the completion of the program, each resident **must** have the following experiences in the administration of the full spectrum of anesthesia service for same-day surgery dental patients:

1. At least one hundred (100) cases of the experiences listed in Standard 2-6 in outpatient anesthesia for dentistry that are supervised by dentist anesthesiologists.
2. Experience as the provider of supervised anesthesia care.

### **Accreditation Standards for Advanced Dental Education Programs in Dental Public Health**

#### **Preface**

The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable **elderly**. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

**Accreditation Standards for Advanced Dental Education Programs in Endodontics****Preface**

The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

4-8 The educational program must provide in-depth instruction and clinical training so that students/residents are competent in:

f. Management of endodontic treatment of medically compromised patients;

**Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Surgery****Preface**

The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

4-8 The program must ensure a progressive and continuous outpatient surgical experience, including preoperative and postoperative evaluation, as well as adequate training in a broad range of oral and maxillofacial surgery procedures involving adult and pediatric patients. This experience must include the management of dentoalveolar surgery, the placement of implant devices, traumatic injuries and pathologic conditions, augmentations and other hard and soft tissue surgery, including surgery of the mucogingival tissues. Faculty cases may contribute to this experience, but they must have resident involvement.

4-9 The off-service rotation in anesthesia must be supplemented by longitudinal and progressive experience throughout the training program in all aspects of pain and anxiety control. The ambulatory oral and maxillofacial anesthetic experience must include the administration of general anesthesia/deep sedation for oral and maxillofacial surgery procedures to pediatric, adult, and geriatric populations, including the demonstration of competency in airway management.

4-9.1 The cumulative anesthetic experience of each graduating resident must include administration of general anesthesia/deep sedation for a minimum of 300 cases. This experience must involve care for 50 patients younger than 13. A minimum of 150 of the 300 cases must be ambulatory anesthetics for oral and maxillofacial surgery outside of the operating room.

**Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Pathology****Preface**

The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable **elderly**. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

4-2.2 Although quality of education is stressed, the laboratory must receive at least 2000 oral and maxillofacial pathology accessions of adequate variety annually.

**Accreditation Standards for Advanced Dental Education Programs in Oral and Maxillofacial Radiology****Preface**

The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable **elderly**. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

**Accreditation Standards for Advanced Dental Education Programs in Oral Medicine**

**2-10** Formal instruction in the biomedical sciences **must** enable graduates to:

- a) detect and diagnose patients with complex medical problems that affect various organ systems and/or the orofacial region according to symptoms and signs (subjective/objective findings) and appropriate diagnostic tests;
- b) employ suitable preventive and/or management strategies (e.g. pharmacotherapeutics) to resolve oral manifestations of medical conditions or orofacial problems; and

**2-12** The educational program **must** provide training to the level of competency for the resident to:

- a) perform a comprehensive physical evaluation and medical risk assessment on patients who have medically complex conditions and make recommendations for dental treatment plans and modifications;

**Accreditation Standards for Advanced Dental Education Programs in Orofacial Pain****Definition of Terms**

**Patients with **special needs**:** Those patients whose medical, physical, psychological, or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, complex medical problems, and significant physical limitations.

**Accreditation Standards for Advanced Dental Education Programs in Orthodontics and Dentofacial Orthopedics****Preface**

The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

**Accreditation Standards for Advanced Dental Education Programs in Periodontics****Preface**

The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

4-6 Each student/resident must: (a) treat a variety of patients with different periodontal diseases and conditions as currently defined by The American Academy of Periodontology; and (b) complete an adequate number of documented moderate to severe periodontitis cases to achieve competency

4-7 An ongoing record of the number and variety of clinical experiences accomplished by each student/resident must be maintained. This must include periodontal diagnosis, disease severity, periodontal treatment, as well as patient's age, gender and health status.

**Accreditation Standards for Advanced Dental Education Programs in Prosthodontics****Preface**

The profession has a duty to consider patients' preferences, and their social, economic and emotional circumstances when providing care, as well as to attend to patients whose medical, physical and psychological or social situation make it necessary to modify normal dental routines in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairments, complex medical problems, significant physical limitations, and the vulnerable elderly. The Standards reconfirm and emphasize the importance of educational processes and goals for comprehensive patient care and encourage patient-centered approaches in teaching, research and oral health care delivery.

4-13 Instruction must be provided at the understanding level in each of the following clinical areas:  
e. Geriatric considerations in prosthodontic care;

## **Standards for Allied Dental Education Programs**

### **Accreditation Standards for Dental Hygiene Education Programs**

#### **Definition of Terms**

**Patients with special needs:** Those patients whose medical, physical, psychological, or social situations make it necessary to modify normal dental routines in order to provide dental treatment for that individual. These individuals include, but are not limited to, people with developmental disabilities, complex medical problems, and significant physical limitations.

2-8d Dental hygiene science content must include oral health education and preventive counseling, health promotion, patient management, clinical dental hygiene, provision of services for and management of patients with special needs, community dental/oral health, medical and dental emergencies, legal and ethical aspects of dental hygiene practice, infection and hazard control management, and the provision of oral health care services to patients with blood borne infectious diseases.

2-12 Graduates must be competent in providing dental hygiene care for the child, adolescent, adult and geriatric patient.

#### **Graduates must be competent in assessing the treatment needs of patients with special needs.**

##### **Intent:**

*An appropriate patient pool should be available to provide a wide scope of patient experiences that include patients whose medical, physical, psychological, or social situations may make it necessary to modify procedures in order to provide dental hygiene treatment for that individual. Student experiences should be evaluated for competency and monitored to ensure equal opportunities for each enrolled student.*

*Clinical instruction and experiences with special needs patients should include instruction in proper communication techniques and assessing the treatment needs compatible with these patients.*

### **Accreditation Standards for Dental Laboratory Technology Education Programs**

- No standards mention geriatric dentistry and/or patients with special needs.

### **Accreditation Standards for Dental Therapy Education Programs**

#### **Definition of Terms**

**Patients with special needs:** Those patients whose medical, physical, psychological, cognitive or social situations make it necessary to consider a wide range of assessment and care options in order to provide dental treatment. These individuals include, but are not limited to, people with developmental disabilities, cognitive impairment, complex medical problems, significant physical limitations, and the vulnerable elderly.

**2-13** Didactic dental sciences content **must** ensure an understanding of basic dental principles, consisting of a core of information in each of the following areas within the scope of dental therapy:  
o. geriatric dentistry

**2-14** Graduates **must** be competent in managing a diverse patient population and have the interpersonal and communications skills to function successfully in a multicultural work environment.

**Intent:** *Students should learn about factors and practices associated with disparities in health status among populations, including but not limited to, racial, ethnic, geographic, or socioeconomic groups. In this manner, students will be best prepared for dental therapy practice in a diverse society when they learn in an environment characterized by, and supportive of, diversity and inclusion. Such an environment should facilitate dental therapy education in:*

- *basic principles of culturally competent health care;*
- *recognition of health care disparities and the development of solutions;*
- *the importance of meeting the health care needs of dentally underserved populations, and;*
- *the development of core professional attributes, such as altruism, empathy, and social accountability, needed to provide effective care in a multi-dimensionally diverse society.*

*Dental therapists should be able to effectively communicate with individuals, groups and other health care providers. The ability to communicate verbally and in written form is basic to the safe and effective provision of oral health services for diverse populations. Dental therapists should recognize the cultural influences impacting the delivery of health services to individuals and communities (i.e. health status, health services and health beliefs).*

**2-20** Graduates **must** be competent in providing oral health care within the scope of dental therapy to patients in **all stages of life**.

Year	Course Number	Title	Description	Speaker	Registration	Capacity	Free/Paid
2016	6317	Dentistry's Answer to Medical Longevity: Why it's Time for a Paradigm Shift?	America is aging and fast. Do we as dentists have what it takes to face the challenges of longevity and its repercussions on the oral cavity? Whether we like it or not we are all going to be geriatric dentists eventually. This presentation highlights why we need to embrace practicing geriatric dental medicine and how we can hope to achieve this paradigm shift in clinical practice.	Kadambari Rawal	111	112	Free
2016	6305	Something to Chew On: Taking Care of Elderly Patients	Just like all of us, our patients are advancing in years and are facing some complicated age-related consequences. This course will chew on the facts and spit out potential solutions that will help participants and their patients age tastefully.	Judy Bendit	233	233	Free
2016	7305	The Older Adult: New Face of Addiction	This course will examine the widespread problem of substance abuse and addiction among older adults. Elderly adults present with higher risks for cancer, infections and infectious diseases due to past and continued use of alcohol, tobacco and illicit drugs. The number of adults aged 50 and older with substance abuse disorders is expected to double by 2020 across genders, ethnicities and all age groups. Dependency on prescription drugs is widespread with a multifactorial etiology. Strategies for how to safely manage these patients in the dental setting will also be discussed.	Ann Spolarich	140	140	Free
2016	8205	Tray Options for Bleaching, Sensitivity and Caries Control	Attendees will construct a custom bleaching tray on a properly trimmed cast. Casts will be provided for patient demonstration. Other options, such as boil and form disposable trays, single dark teeth trays, sensitivity treatment with tray application of potassium nitrate, and caries control in elderly patients will be addressed.	Van Haywood	12	30	Paid
2017	5373	Back to Your Future, Geriatric Dentistry!	Our population is aging and seniors often have special dental needs and complicated histories that require careful consideration. This presentation will review dental diseases that most effect our older patients and what are current and possible future treatment options for these diseases. Discussion will include use of silver diamine fluoride and delivering portable care.	Charles Doring	182	200	Free
2017	7126	Comprehensive Health Prevention for Older Adults	Attainment of optimal oral health and wellness is a challenging and dynamic process that occurs along the aging continuum. This course will present a new model of health prevention for older adults, with an emphasis on ensuring safety, minimizing disease risks, maintaining function, and optimizing oral health quality of life. Oral health care professionals will learn how to individualize preventive strategies to improve desired health outcomes for their elderly patients.	Ann Spolarich	12	112	Paid
2017	7219	7 Tray Options for Tooth Whitening, Sensitivity and Caries Control	Participants in this course will construct and adjust a custom bleaching tray on a properly trimmed cast. Casts will be provided for all course participants to use and take with them for patient demonstration purposes.	Van Haywood	5	30	Paid
2018	5805	Using Telehealth Technology to Reach Under-served Populations	Telehealth technology is playing an increasing role in the delivery of health care nationally. It is now possible to reach underserved groups through expanded teams using telehealth strategies that employ cost-effective methods. Learn about team organization, equipment needed, communication strategies and considerations for working within individual state's legal and regulatory environments to make telehealth a reality.	Paul Glassman	353	470	Free
2019	6159	Oral Health for Healthy Ageing: 5 Years of Promotion, Prevention and Solutions	<p>This year, OHAP is focusing on prevention (through good oral hygiene) and treatment (adapted to the special needs of the elderly) and worked on developing practical guides for oral health professionals and patients. On one hand, oral health professionals will have the tools to assess their patients and their oral health in the context of their dependency. On the other hand, patients will be provided with tailored guidelines to help them take care of their oral health based on their level of dependency.</p> <p>In addition, this session will further promote the advocacy and strategic documents developed by the OHAP Task Team in 2018. These documents highlight a series of actions that interested stakeholders can use to positively engage with the elderly community.</p> <p>Dr. Sophie Dartevelle - "The Advocacy Tools for the Oral Health of an Ageing Population to Guides on the Daily Practices of Dentists, Caregivers and Elderly Patients Themselves"</p> <p>Dr. Judith Jones - "The Settle Care Pathway"</p> <p>Dr. Kakuhiro Fukai - "Closing the Global Oral Health Gap and Renewing Our Healthcare system for an Ageing Population"</p>	Judith Jones	13	321	Paid

2019	7137	Baby Boomers: From Periodontitis to Xerostomia and Beyond	The over age 55 population will increase significantly We now see a major increase/frequency of oral conditions, such as chronic inflammation and tooth loss periodontitis, xerostomia with compromised lifestyle, and root caries that's difficult to find and treat. This course will review these primary diseases, from diagnosis to management, with an emphasis on dry mouth, nonsurgical periodontal care, and reducing root caries. Learn effective patient scripting for positive case acceptance.	Samuel Low	54	297	Paid
2019	6116	Management of Root Caries in Older Adults	Root surface caries is increasingly common among older adults as they are retaining more natural teeth into older age. Management of root caries includes prevention of new caries and treatment of the existing carious lesions. This lecture will focus on a review of the clinical evidence of the various agents that are effective in preventing and/or arresting root caries. Clinical indications and protocols for using these agents will be presented and discussed.	Edward Lo	101	450	Paid
2020	n/a	Making Oral Health a Priority for Older Adults	The course will discuss the future of dentistry as we prepare to treat an exploding population of older Americans. The course will review special considerations for the dental team to keep in mind when treating the elderly with complicated medical and dental needs. Easy ways to provide dental care in non-traditional settings, such as long term care facilities will be considered. The ADA's "Dentistry in Long Term Care: Creative Pathways to Success" as well as the Maryland State Dental Association's "Long Term Care Dental Initiative" will be reviewed. New techniques and procedures for preventing and treating dental root caries, such as use of silver diamine fluoride will also be discussed and cases presented.	Charles Doring			
2020	n/a	Comprehensive Health Prevention for Older Adults	Attainment of optimal oral health and wellness is a challenging and dynamic process that occurs along the aging continuum. This course will present a new model of health prevention for older adults, with an emphasis on ensuring safety, minimizing disease risks, maintaining function, and optimizing oral health quality of life. Oral health care professionals will learn how to individualize preventive strategies to improve desired health outcomes for their elderly patients.	Ann Spolarich			
2020	n/a	Oral Surgery in the Elderly	The aging of our population presents the dental team with increasing challenges when older patients require oral surgery. Even a "simple" extraction can become complex due to the patient's medical conditions, medication interactions and side-effects or mental status. Provide excellent care while eliminating "headaches" for you and your staff by learning simple techniques Dr. Huffines uses in his own practice. Some of the topics discussed are: hemostatic techniques for patients on "blood thinners", local anesthesia in older patients, new instruments, simple pre-prosthetic surgery, endocarditis prophylaxis myths, managing common medical conditions (including hypertension, diabetes, stroke and Alzheimer's disease), medication interactions and side-effects, ecchymosis, anxiolysis, new extraction instruments, and pain control in the elderly. Special emphasis is given to learning how to avoid complications that are become more common as we age. Techniques are clearly explained by extensive use of clinical images and video clips so they can immediately be put into practice. In addition to handouts, course participants will be given free access to online patient resources they can customize for their practices.	Randy Huffines			
2020	n/a	Geriatrics for Hygienists	Providing quality dental care for older patients can be very rewarding but also very challenging. In this entertaining and informative presentation, solutions to common everyday problems that arise with older patients are clearly explained to give you increased confidence when treating seniors. Learn practical tips on root caries, wheelchair transfers, fluoride varnishes, medical conditions of concern, patient-specific preventive strategies, communicating with the visual and/or hearing impaired, proper patient positioning, aging and periodontal disease, remineralization products, implants, marketing to seniors, denture care, and medication side-effects (including bisphosphonates). In addition to handouts, course participants will be given free access to online resources they can use in their practices.	Randy Huffines			

## **Continuing Education Courses Related to Elder Care/Geriatrics via CE Online**

- [Oral Health Topics: Aging and Dental Health](#)
- [Clinical Complications In Fixed Prosthodontics: Causes, Prevention, and Management, Part 4](#)
- [Using the Beers criteria to identify potentially inappropriate medication use by older adult dental patients \(May 2017 Article 3\)](#)
- [Tooth loss among older adults according to poverty status in the United States from 1999 through 2004 and 2009 through 2014 \(January 2019 Article 1\)](#)
- [Preventive dental care in older adults with diabetes \(October 2016 Article 3\)](#)
- [Strategies to improve dental health in elderly patients with cognitive impairment \(April 2017 Article 3\)](#)
- [Local Anesthesia Part 9: What's New in Dental Local Anesthesia?](#)
- [Emergency Medicine Part 9: Cardiac Arrest](#)

Resolution No. 79 New

Report: N/A Date Submitted: August 2019

Submitted By: Fourteenth Trustee District

Reference Committee: C (Dental Education, Science and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

# 1 GATHERING EVIDENCE TO DEVELOP POLICY REGARDING CANNABIS USE

2 The following resolution was adopted by the Fourteenth Trustee District and submitted on August 9,  
3 2019, by Dr. David White, caucus chair, Fourteenth District.

4 **Background:** Although legalized cannabis and cannabidiol (CBD) products are being sold across the  
5 United States, the American Dental Association (ADA) has very limited information available to its  
6 members and the public regarding the effect of such products on oral health. As the national authority on  
7 oral health care the ADA should encourage studies on the effects of cannabis and CBD products on oral  
8 health.

## 9 Resolution

10 **79. Resolved,** that the ADA encourage research and data gathering on the effect of  
11 cannabis and cannabidiol (CBD) products on the dentition and surrounding oral mucosa, so  
12 that policy and guidelines can be developed to help the profession meet the needs of the  
13 patients.

14 **BOARD RECOMMENDATION: Vote Yes.**

## 15 Vote: Resolution 79

BLACK	Yes	GEHANI	Yes	KLEMMEDSON	Yes	RODRIGUEZ	Absent
COHLMIA	No	HARRINGTON	Yes	KYGER	Yes	SABATES	Yes
DOROSHOW	Yes	HERRE	Yes	LEARY	Yes	SHEPLEY	Yes
EDGAR	Yes	HIMMELBERGER	Yes	MCDUGALL	Yes	STEPHENS	Yes
FISCH	Yes	HUOT	Yes	NORBO	Yes	THOMPSON	Yes

Resolution No. None N/AReport: Council on Dental Education and Licensure Report 1 Date Submitted: July 2019Submitted By: Council on Dental Education and LicensureReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

## COUNCIL ON DENTAL EDUCATION AND LICENSURE REPORT 1 TO THE HOUSE OF DELEGATES: SELF-ASSESSMENT

**Background:** In accord with Resolution 41H-2018, the Council on Dental Education and Licensure conducted a self-assessment in 2019 through the conduct of an electronic survey to members who served 2016-2019; the results were discussed by the Council in June 2019 and are reported below.

Overall, the Council was satisfied with the composition (eight ADA members appointed by the House of Delegates, four members appointed by the American Dental Education Association and four members appointed by the American Association of Dental Boards), structure and function of the Council and its standing committees, allowing for productive and efficient meetings. The Council agreed that the current areas of responsibility as described in the *Governance and Organizational Manual* are relevant. All survey respondents felt that in-person Council meetings are valuable or extremely valuable because they foster better discussion, allow members to focus all their attention on CDEL matters and allow for collaboration and the development of camaraderie between members. The Council concurred that two in-person meetings per year is the most effective method for conducting CDEL meetings. The Council discussed how to enhance standing committee and Council conference call meetings and increase usage of ADA Connect. The Council also discussed the roles and responsibilities of councils, commissions and staff, and how these agencies can collaborate more effectively for the benefit of members and the public.

The Council concluded that its duties align with and support the current strategic plan, Members First 2020, as well as the upcoming strategic plan, Common Ground 2025. Reasons given include the progress toward the elimination of patients in dental licensure examinations, increased licensure portability which will impact membership and supporting the advancement of health of the public by strengthening educational standards. The sentiment that CDEL has some impact on every goal and objective of the ADA was noted. Members of the Council concluded that the agency should continue to exist as currently charged and structured.

### Resolutions

This report is informational and no resolutions are presented.

**BOARD RECOMMENDATION: Vote Yes to Transmit.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. None N/AReport: Board Report 7 Date Submitted: July 2019Submitted By: Board of TrusteesReference Committee: C (Dental Education, Science and Related Matters)Total Net Financial Implication: None

Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_

Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 3: 10% increase in assessment of member value

How does this resolution increase member value: See Background

**REPORT 7 OF THE BOARD OF TRUSTEES: ADA LIBRARY AND ARCHIVES ADVISORY BOARD  
ANNUAL REPORT**

**Background:** In November 2013, the ADA House of Delegates approved the ADA Library and Archives Transition Plan, including the establishment of a volunteer board to oversee operations of the ADA Library and Archives. An engaged and functioning advisory board is considered a best practice for library management. The ADA Library and Archives Advisory Board serves in an advisory capacity to the Board of Trustees.

At its August 2019 meeting, the Board of Trustees approved the appended Annual Report of the ADA Library Archives Advisory Board for transmittal to the 2019 House of Delegates.

**Resolutions**

This report is informational and no resolutions are presented.

**BOARD RECOMMENDATION: Vote Yes to Transmit.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO  
BOARD DISCUSSION)**

## Appendix 1

# ADA Library & Archives Advisory Board

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Fisch, Judith, 2019, Board of Trustees, 1st District (chair)  
 Doroshov, Susan, 2019, Board of Trustees, 8<sup>th</sup> District  
 Mariotti, Angelo, 2019, Ohio, Council on Scientific Affairs  
 Parker, William, 2019, Florida, Council on Scientific Affairs  
 Korzeb, Jennifer, 2019, Massachusetts, Council on Dental Education and Licensure  
 Miles, Maurice, 2019, Maryland, Council on Dental Education and Licensure  
 Hayes, Mary, 2019, Illinois, at-large Member  
 Ishkanian, Emily, 2020, Nevada, at-large Member  
 Nevius, Amanda, 2020, public member, special/dental librarian  
 Nickisch Duggan, Heidi, director, ADA Library & Archives  
 Fleming, Anna, electronic resources & research services librarian, ADA Library & Archives  
 Matlak, Andrea, archivist & metadata librarian, ADA Library & Archives  
 O'Brien, Kelly, informationist, ADA Library & Archives  
 Pontillo, Laura, coordinator, ADA Library & Archives  
 Strayhorn, Nicole, NLM Fellow, ADA Library & Archives

## **Areas of Responsibility as Set Forth in the *Bylaws or Governance and Organizational Manual of the American Dental Association***

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The areas of responsibility for the ADA Library & Archives Advisory Board (LAAB) are as follows:

- Creating and developing the mission and strategic plan of the ADA Library & Archives.
- Ensuring that the ADA Library & Archives remain relevant to the ADA strategic plan.
- Providing input during the annual ADA budgeting process on library funding, priorities and needs.
- Adopting policies and rules regarding library governance, assets and use; developing, approving, and codifying all policies, based on input from the library staff; also delegating procedural work to the library staff.
- Regularly planning and evaluating the library's service program.
- Evaluating the library facility to ensure that it continues to meet ADA member and ADA staff needs.
- Launching a marketing plan for the promotion of the ADA Library & Archives to ADA members; ADA component and constituent societies; the local dental and medical communities; and affiliated dental organizations.
- Conducting the business of the library in an open and ethical manner in compliance with all applicable laws and regulations and with respect for the association, staff and public.

## **Advancing ADA Strategic Goals and Objectives: Agency Programs, Projects, Results and Success Measures**

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### **Objective 1: Grow Active, Full Dues Paying Membership**

#### **Initiative/Program: Scientific Support/Utilization of Library Content**

**Success Measure:** Achieve a 5% annual increase in the number of user searches via electronic resources by December 2019.

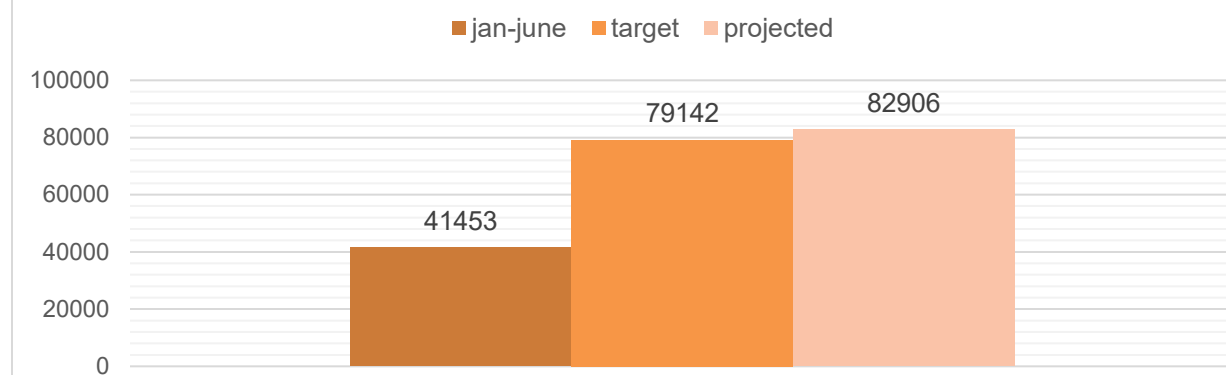
**Target: 79,142 (Regular and automated searches)**

**Range: 75,000-80,000**

**Outcome: On Target, likely to exceed**

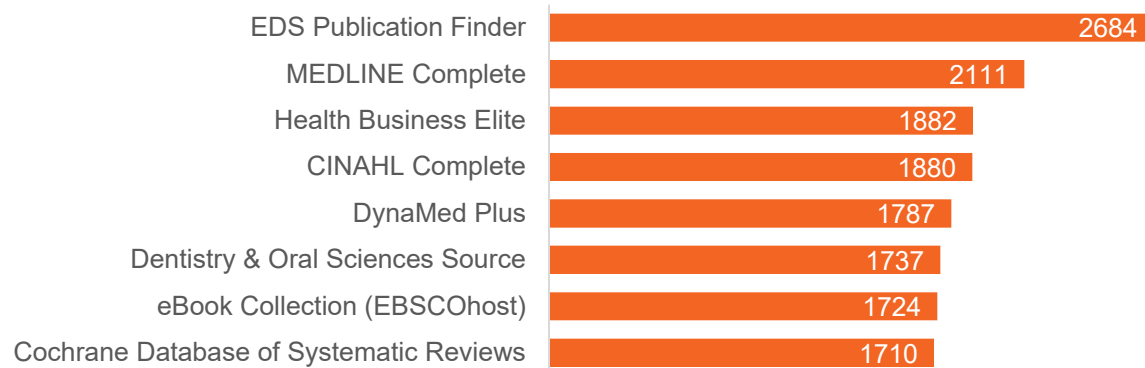
Usage statistics from the first quarter of 2019 show continued increased use of the Library's electronic resources (journals, databases, e-books, clinical resources). Projecting to the end of 2019, ADA members and staff are anticipated to conduct approximately 79,142 online searches (over 2018's 75,373 regular and automated searches) of online resources as Members become more aware of the library's growing electronic resources.

**Table 1. Database Searches, Regular\* and Automated\*\*  
January-June 2019**



\*Regular Searches refers to the number of times a user searches a database, where they have actively chosen that database from a list of options OR there is only one database available to search.

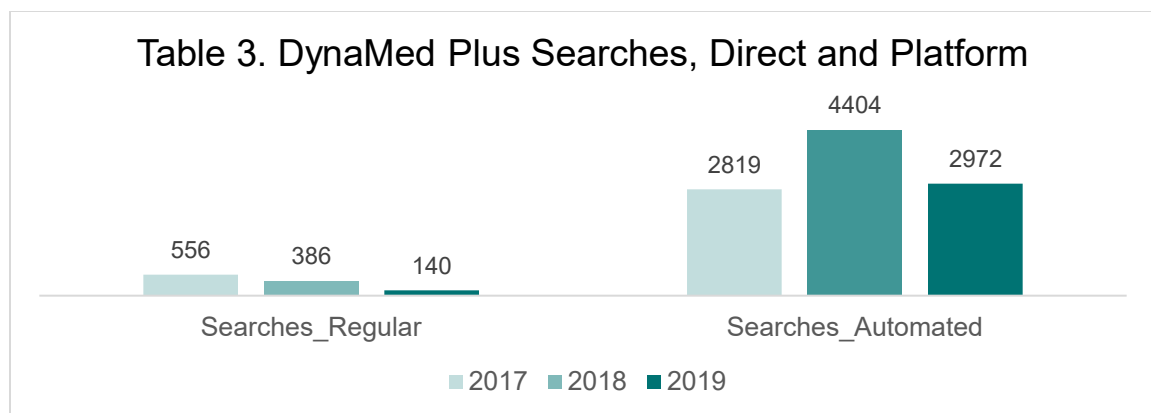
\*\* Automated Searches refers to the number of times a user searches a database, where they have not actively chosen that database from a list of options. That is, Searches Automated is recorded when the platform offers a search across multiple databases by default, and the user has not elected to limit their search to a subset of those databases.

Table 2. Top Featured Databases by Regular Searches,  
2019 Q1

1

2 DynaMed Plus, an evidence-based resource of drug information and clinical summaries intended to  
 3 reduce time-to-answer, is available through the ADA Library & Archives website. Future 2019  
 4 enhancements include CE via DynaMed Plus.

Table 3. DynaMed Plus Searches, Direct and Platform



5

## 6 Objective 2: Grow Active, Full Dues Paying Membership

7

### 8 Initiative/Program: Scientific Support/Utilization of Library Content

9

10 **Success Measure:** Achieve a 5% annual increase in the number of unique item investigations and full-  
 11 text downloads via electronic resources by December 2019.

12

13 **Target:** 18,092

14

15 **Range:** 17,500-18,500

16

17 **Outcome:** On Target, likely to exceed

- 1 Downloads and unique item investigations (the number of unique content items (e.g. chapters)  
2 investigated by a user) are more difficult to predict because ADA staff and members tend to search for  
3 known items and ask for staff assistance when conducting more open research, for instance, to answer a  
4 clinical question. As a result, ADA Library & Archives staff search more broadly, thus increasing the total  
5 search numbers but selecting fewer and more focused full-text downloads than the typical user might.  
6 ADA Library & Archives service goals influence sending only the most relevant full-text downloads  
7 combined with abstracts and citations to prompt user evaluation.

Table 4. Top 10 Journal Title Usage by Article Downloads,  
Q1 2019

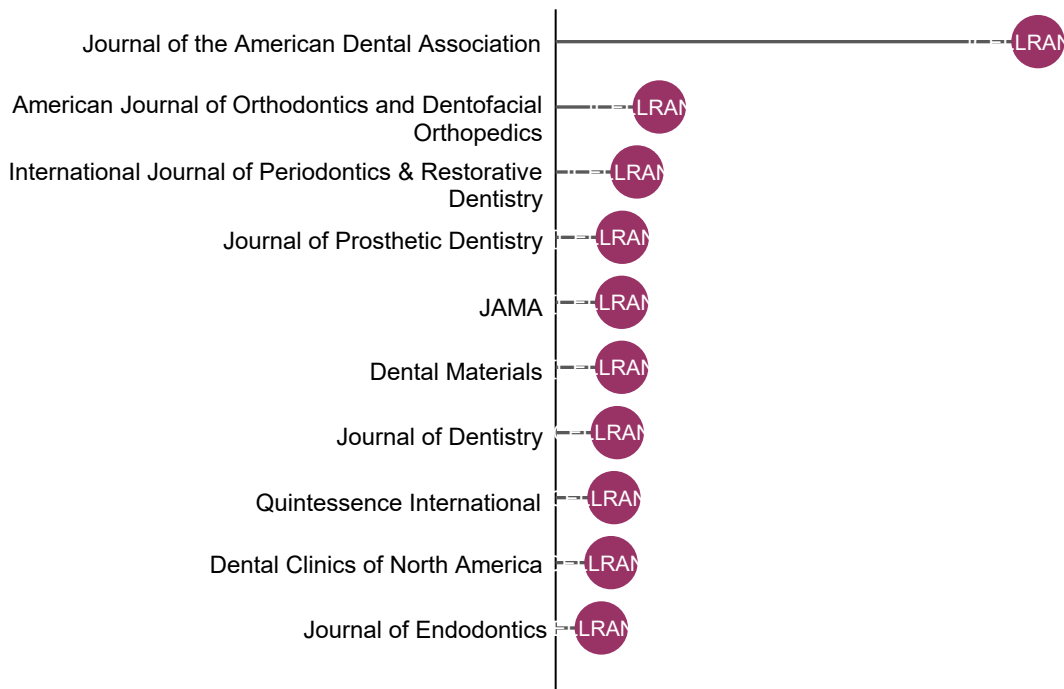
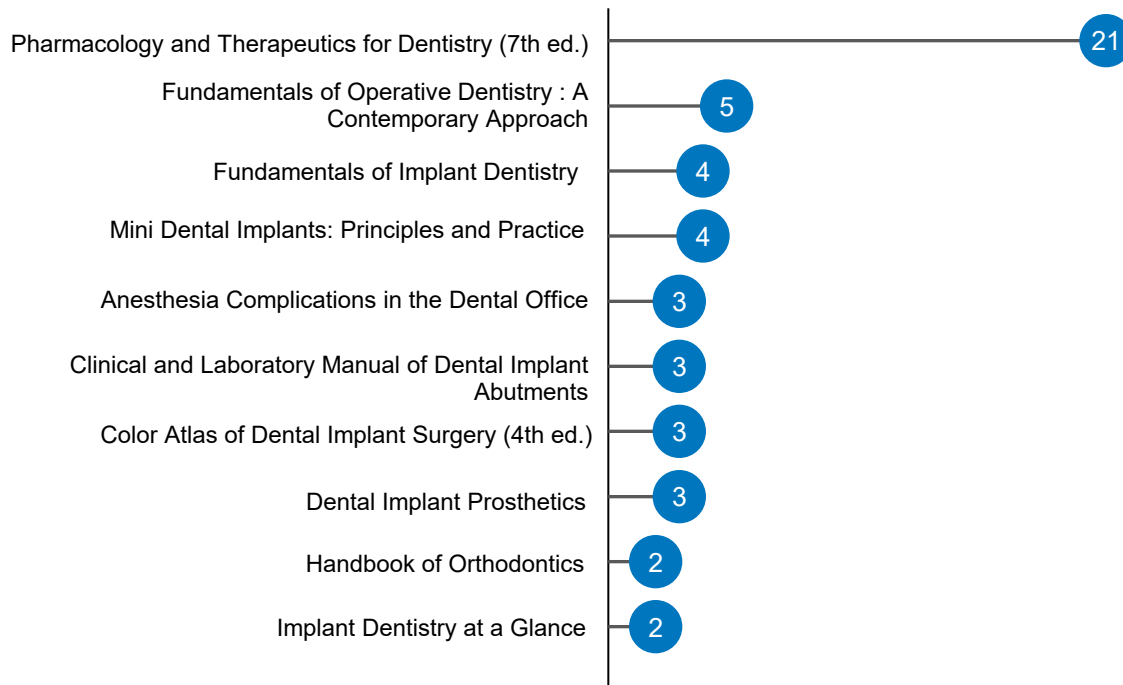


Table 5. Top 10 eBook Title Usage, Q1 2019

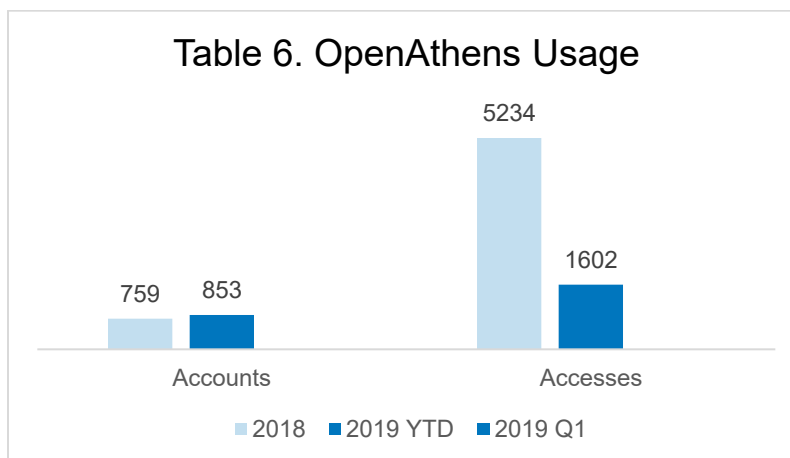


## Emerging Issues and Trends

Libraries continue to maximize resources through the expanded use of digital and electronic means to convey information to their patrons. The ADA Library & Archives continually reviews these rapid changes in order to remain relevant to ADA Members and the profession. The LAAB is committed to:

- Providing efficient searching using current eResources and making the Library & Archives a 24/7 knowledge center. This is partially accomplished by the implementation of DISCOVERY and OpenAthens, an identity access management tool that allows members to access subscribed electronic content 24/7.

Table 6. OpenAthens Usage



- Maintaining and developing a comprehensive collection of evidence-based and clinical information sources for ADA members in appropriate formats. The current staff roles allow for faster, more robust reference assistance and user education, expert searching, and new means of engaging with members.
- Continued interlibrary loan (ILL) services to provide ADA Staff and members with scholarly articles not held in the collections of the ADA Library & Archives (borrowing), and providing those same services to outside researchers via other libraries (lending).

Table 7. ILL Borrowing Requests

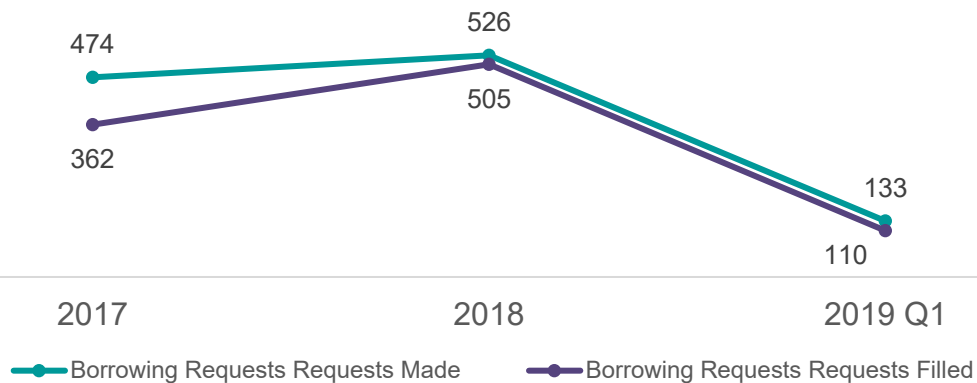


Table 8. ILL Lending Requests



- Continuous support of various information needs of the Division of Science. The ADA Library & Archives staff actively engages in expert searching for EBD clinical guideline development and systematic reviews, provides education and access to evidence-based clinical tools and drug information, and provides expert support for initiatives such as 86H-2016, a HOD-directed initiative to provide information on dental clearance for specific conditions and procedures.
- Archives expert support for ADA administration and operations provides information on organizational and dental history for policy and product development, legal review, marketing, communications, and public relations.

- Developing new success measures that emphasize impact on policy outcomes, impact on clinical practice, and the research productivity of ADA members and staff.
- Developing online tutorials, instructional videos, and CE courses for members to assist in their acquisition of evidence-based clinical research materials and search skill enhancement, as well as database navigation and use.
- Expanded data visualization services. National Library of Medicine (NLM) Associate Fellow Nicole Strayhorn will spend her second fellowship year at the ADA Library & Archives in 2018-2019, providing expertise in data management and data visualization to librarians, health economists, statisticians, data analysts, and health services researchers throughout the ADA and beyond. Successes in 2019 include the National Member Data Dashboard, consults with Division of Science, and visualizations for the ADA Sip N Snack patient brochure.

## **Policy Review**

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The Library & Archives Advisory Board will have its annual meeting in fall, 2019.

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## Legislative, Health, Governance and Related Matters

Resolution No. 1 NewReport: N/A Date Submitted: May 2019Submitted By: Board of TrusteesReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None

Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_

Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

## AMENDMENT OF THE ADA BYLAWS TO CLARIFY CHAIR VOTING

**Background:** The ADA *Bylaws* currently provide with respect to the chair of the Board of Trustees: “The Chair shall preside at all meetings of the Board of Trustees. The Chair may cast a vote only in instances where there is a tie vote and the tie does not by itself determine the outcome of the vote.” *Bylaws*, Chapter V, Section 110. This provision typically applies to the President. It also applies to anyone presiding as chair of the Board, for example, the President-elect in the President’s absence.

It is important to note that the circumstances in which a chair may vote are very limited. If a motion or resolution results in a tie vote, for example, the motion or resolution fails and the chair does not vote. The one exception is when the Board must decide among multiple candidates for a single position. In this case, a tie vote is not dispositive. Under this provision, in this limited circumstance, the chair may vote.

The meaning of this provision is not clear from a reading of the *Bylaws*. The Board proposes amending this provision simply to more clearly state this rule. Accordingly, the Board proposes changing the provision to: “The Chair shall preside at all meetings of the Board of Trustees. The Chair may vote only in the event of a tie vote on a ballot to fill a single position from among multiple candidates.” This does not change the substance of the provision but will aid future Boards by enhancing clarity.

### Resolution

**1. Resolved**, that CHAPTER V. BOARD OF TRUSTEES, *Section* 110. OFFICERS, B. DUTIES, a. CHAIR, of the ADA *Bylaws* be amended as follows (additions underscoring; deletions ~~stricken through~~):

#### B. DUTIES.

a. CHAIR. The Chair shall preside at all meetings of the Board of Trustees. The Chair may vote only in the event of a tie vote on a ballot to fill a single position from among multiple candidates. ~~The Chair may cast a vote only in instances where there is a tie vote and the tie does not by itself determine the outcome of the vote.~~

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS.**

Resolution No. 2 New

Report: N/A Date Submitted: May 2019

Submitted By: Board of Trustees

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

## AMENDMENT OF ADA CONFLICT OF INTEREST DISCLOSURE POLICY

**Background:** The Board is proposing a minor edit to the Disclosure Policy contained in the first resolving clause of Resolution 63H-2014. The Board supports continued use of the policy. As currently written, the policy requires disclosure “at this time,” when the statement is read or brought to the attention of the House, Board, Council or other body. The Board believes disclosure is better made at the time the particular subject giving rise to the potential conflict is brought forward for discussion. This is already the practice at the House of Delegates.

Accordingly, the Board proposes changing “at this time” to “at the appropriate time.”

### Resolution

**2. Resolved**, that the ADA Conflict of Interest Policy (Disclosure Policy) (*Trans.*2010:624; 2011:537; 2013:341) be amended as follows: (additions underscored, deletions ~~stricken through~~):

**Resolved**, that chairs of any meeting of the ADA, including Executive Committee, Board of Trustees, councils, committees and the House of Delegates include the disclosure policy as a written part of the agenda at each meeting:

In accordance with the ADA Disclosure Policy, ~~at this time~~ at the appropriate time anyone present at this meeting is obligated to disclose any personal, professional or business relationship that they or their immediate family may have with a company, professional organization or individual doing business with the ADA, when such company, professional organization or person is being discussed. This includes, but is not limited to insurance companies, sponsors, exhibitors, vendors and contractors.

and be it further

**Resolved**, that the disclosure policy be read at the opening of each meeting of the House of Delegates, and be it further

**Resolved**, that when speaking on the floor of the House of Delegates or in Reference Committees, those individuals/members shall first identify those relationships before speaking on an issue related to such conflict of interest.

- 1 **BOARD RECOMMENDATION: Vote Yes.**
- 2 **BOARD VOTE: UNANIMOUS.**

Resolution No. 3 New

Report: N/A Date Submitted: May 2019

Submitted By: Board of Trustees

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

## 1 **AMENDMENT OF THE ORGANIZATION AND RULES OF THE BOARD OF TRUSTEES: RECORDED** 2 **BOARD VOTES**

3 **Background:** The *Organization and Rules of the Board of Trustees* (Board Rules) require the Board to  
4 record each member's vote on all resolutions being forwarded to the House of Delegates, including Board  
5 comments and recommendations relating to resolutions proposed by councils, districts or others. The  
6 genesis of this requirement is a 1981 House resolution:

7  
8 **88H-1981. Resolved,** that the Board of Trustees be encouraged to vote on all matters when  
9 requested to do so, and be it further

10  
11 **Resolved,** that on ADA Board of Trustees reports, white papers, resolutions or recommendations  
12 to the House of Delegates the individual trustee vote will be recorded by name, and be it further

13  
14 **Resolved,** that on all votes of the Board of Trustees all abstentions and absences will be  
15 recorded by name.

16  
17 In reviewing our Association's practices and advice of experts, the Board has concluded that the  
18 Association would be better served were this policy rescinded. This is a best practice. Every year, the  
19 new officers and trustees attend a symposium presented by the American Society of Association  
20 Executives (ASAE) and, last year, this topic was explicitly addressed. ASAE's recommendation was that  
21 associations should not record individual votes. (The remaining provisions of 88H-1981 relate to internal  
22 Board management.) In considering the matter, the Board agrees and asks the House to rescind this  
23 policy.

24  
25 A number of considerations support this request:

- 26
- 27 • The Board is the managing body of the Association and as such has a responsibility to set  
28 governance rules and policies that allow it to effectively administer the policies and programs of  
29 the ADA for the benefit of all members. In that role the Board is charged to seek out best  
30 practices for governance and should be able to apply them to its processes.
  - 31
  - 32 • Current policy regarding recording of Board votes may lead to division within the Board and a less  
33 cohesive and less effective management.

- The House is entitled to the full and frank opinions of the Board on the matters coming before the House. The value of a diverse board is the wisdom of the many. The recommendation of the full Board is more valuable for effective management than the collection of individual votes. Changing current policy will help to assure that this is exactly what the House will receive.
- Board members are to bring to the Board the perspective of their district, but their fiduciary obligation is to vote in the best interest of the Association as a whole. Recording votes may place unnecessary pressure on Board members to vote in the interest of a particular district in possible violation of this fiduciary duty.
- Rightly or wrongly, politics is seen as influencing the decisions made by Board members. A candidate for President-elect may be seen as voting in a particular way out of concern for the impact of the vote on that Board member's candidacy rather than what is in the best interest of the Association. Changing this policy will lessen the risk of this happening.
- The Board believes the House is entitled to the full and frank opinions of the Board but much has changed since 1981. Direct communication with a Board member, facilitated by technology, is easier now and a better way to disseminate information to House members as compared to the amount of information that can be gleaned from a recorded vote.
- Board members have the right to file a minority report if they feel that is necessary to best communicate information to the House. This right ensures that no information can be hidden from the House.

The Board has a fiduciary responsibility to do what is best for the Association. Accordingly the Board asks the House to consider the following resolution.

### Resolution

**3. Resolved**, that Resolution 88H-1981, Requiring Recording by Name of All Votes of the Board of Trustees (*Trans.*1981:607), be rescinded.

### BOARD RECOMMENDATION: Vote Yes.

#### Vote: Resolution 3

BLACK	Yes	GEHANI	No	KLEMMEDSON	No	RODRIGUEZ	Yes
COHLMIA	Yes	HARRINGTON	Yes	KYGER	Yes	SABATES	No
DOROSHOW	Yes	HERRE	Yes	LEARY	Yes	SHEPLEY	Yes
EDGAR	Yes	HIMMELBERGER	Yes	MCDUGALL	Yes	STEPHENS	Yes
FISCH	Yes	HUOT	Yes	NORBO	Yes	THOMPSON	Yes

**WORKSHEET ADDENDUM**

**ADA POLICY TO BE RESCINDED**

**Requiring Recording by Name of All Votes of the Board of Trustees (*Trans.*1981:607)**

**88H-1981. Resolved,** that the Board of Trustees be encouraged to vote on all matters when requested to do so, and be it further

**Resolved,** that on ADA Board of Trustees reports, white papers, resolutions or recommendations to the House of Delegates the individual trustee vote will be recorded by name, and be it further

**Resolved,** that on all votes of the Board of Trustees all abstentions and absences will be recorded by name, and be it further

**Resolved,** that Resolutions 94aH-1979 (*Trans.*1979:643) and 94bH-1979 (*Trans.*1979:644) be rescinded.

Resolution No. 4 New

Report: N/A Date Submitted: May 2019

Submitted By: Board of Trustees

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: Not Applicable

**AMENDMENT OF THE GOVERNANCE AND ORGANIZATIONAL MANUAL: ELIGIBILITY REQUIREMENTS FOR THE OFFICE OF TREASURER**

**Background:** The *Governance and Organizational Manual of the American Dental Association* ("Governance Manual") prohibits sitting trustees and officers from applying for the office of treasurer:

CHAPTER VI. ELECTIVE OFFICERS OF THE ASSOCIATION

- A. Eligibility. Only an active, life or retired member, in good standing, of this Association shall be eligible to serve as an elective officer. Trustees and elective officers may not apply for the office of Treasurer while serving in any of those offices, except that the Treasurer may apply for a second term as set forth elsewhere in this chapter of the Governance Manual.

*Governance and Organizational Manual*, ch.VI.

The Board agrees that sitting trustees and officers should not be allowed to *serve* as treasurer, but the Board further believes that sitting trustees and officers should be allowed to *apply* for the position. Sitting Board members have direct and valuable experience with the ADA budget process. Excluding these individuals from the pool of potential candidates for the position of Treasurer poses a risk to the Association because in many cases, they may be the best qualified for the position.

Accordingly, the Board is proposing for the House's consideration an amendment to the *Governance Manual* to allow sitting Board members to apply for the office of Treasurer. The Board's proposal further clarifies that no sitting Board member may simultaneously hold the office of Treasurer or Speaker. The proposed resolution requires a two-thirds majority to be approved.

**Resolution**

**4. Resolved**, that *The Governance and Operational Manual*, Ch. VI, section be amended as follows (additions underscored, deletions ~~stricken through~~):

- A. Eligibility. Only an active, life or retired member, in good standing, of this Association shall be eligible to serve as an elective officer. No trustee or other elected officer is eligible to serve simultaneously as Treasurer or Speaker of the House of Delegates. Trustees and elective officers may not apply for the office of Treasurer while serving in any of those offices, except

1                   ~~that the Treasurer may apply for a second term as set forth elsewhere in this chapter of the~~  
2                   ~~Governance Manual.~~

3   **BOARD RECOMMENDATION: Vote Yes.**

4   **BOARD VOTE: UNANIMOUS.**

Resolution No. None N/AReport: Board Report 3 Date Submitted: May 2019Submitted By: Board of TrusteesReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

### REPORT 3 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: COMMON GROUND 2025

**Background:** The Board is pleased to formally present *Common Ground 2025*, the Association's next strategic plan, to the House of Delegates. *Common Ground 2025* was adopted by the Board at its February 2019 meeting and will go into effect on January 1, 2020. A copy of the plan was provided to the House earlier in the year and is appended to this report. "Common Ground" refers to those areas where a mutuality of interest exists among, for example, the profession and the public or the member and the potential member. It is on this common ground where our efforts can be focused for maximum impact.

**Background and Preparation for Developing the Plan:** In August 2018, the Board created a Strategic Planning Workgroup to a draft strategic plan for submission to the Board for its approval. Then-President Joe Crowley appointed the members of the workgroup, including two representatives of the House of Delegates. President Jeffrey Cole reappointed the workgroup after the close of the 2018 House of Delegates. Workgroup members were:

Daniel Klemmedson (Chair), Trustee  
Rita Cammarata, House of Delegates member  
Jeffrey Cole, President  
Chad Gehani, President-elect  
Alex Mitchell, House of Delegates member and new dentist  
Kirk Norbo, Trustee  
George Shepley, Trustee  
James Stephens, Trustee

In addition, the Executive Director, Dr. Kathleen O'Loughlin participated in all aspects of the workgroup's efforts. The Board wishes to express its gratitude to each member of the workgroup.

Timing was an important consideration in the establishment of the workgroup and the completion of its work. A strategic plan should inform and guide budget development. Because 2020 budget development began in the very early spring of 2019, in order to allow that work to be completed in time to present the budget to the House, the new strategic plan needed to be finished early in the year.

Between August 2018 and January 2019, the workgroup reviewed numerous documents and input electronically. In addition to articles, environmental scanning data, and recent research on ADA members and non-members, the workgroup examined the ADA's current strategic plan, information on plan

1 structure and terminology, and preliminary planning work conducted by senior staff as part of the 2020  
2 budget process.

3 The workgroup sought input from the Board of Trustees, the House of Delegates through the 2018 House  
4 survey (in addition to having two House members on the workgroup itself), and all ADA council members.  
5 This was accomplished through surveys and open-ended requests for input. While responses were  
6 varied, the surveys showed general support for the basic structure of the current plan and divergent  
7 opinions on the emphasis the next plan should place of the ADA's role in serving the public.

8 Finally, in January, the workgroup met in person over two days to develop a draft plan to be presented to  
9 the Board. As part of this meeting, the workgroup heard from Seth Green of Loyola University in Chicago  
10 concerning a growing corporate trend among for-profit entities to embrace a social agenda. Mr. Green  
11 pointed out that corporations are doing this both to attract and retain top talent, but also to advance  
12 business goals. The ideal situation for use of a social agenda is when common ground can be found  
13 between the private goals of the entity and the public good. These areas represent the "sweet spot"  
14 ideally suited to the use of a social agenda. An example cited by Mr. Green is Unilever, a major producer  
15 of soaps. Unilever identified a social need to promote hygiene in the third world in order to reduce  
16 disease. This clearly met a social need and, because Unilever was the market leader in the third world, a  
17 campaign to promote hygiene also benefited the corporation's bottom line.

18 The workgroup developed a draft plan and the Board considered that work in February. Based on that  
19 work, the Board adopted *Common Ground 2025*, the Association's next strategic plan.

20 **Some Key Issues:** In developing and approving the strategic plan, the workgroup and the Board  
21 addressed some key issues to determine the basic components of the plan. The first issue deals with the  
22 structure of the plan. It was necessary first to decide whether to retain the basic structure of *Members*  
23 *First 2020*, because that determined what other decisions needed to be made. From there, the Board  
24 looked at the ADA's governing documents at the highest level and agreed upon a new mission statement  
25 and vision statement. Based on this work, the Board identified four high-level goals for the next plan.  
26 The Board further clarified the Association's existing core values and then addressed the objectives under  
27 each of the four goals. The following recaps this work and describes in some detail our new strategic  
28 plan:  
29

- 30 • Basic Plan Structure: The Board recognized the advantages of the current plan's structure  
31 and the fact that the current plan fits on a single sheet of paper. The plan's structure is built  
32 on a hierarchy, from the most all-encompassing and general down to specific and  
33 measurable objectives. The Board decided that the next strategic plan should share the  
34 basic structure used in *Members First 2020*. Accordingly, the plan has a mission statement,  
35 a statement of core values, goals and objectives. In addition, the Board included a vision  
36 statement in this plan.  
37
- 38 • The Mission Statement: According to Article II of the ADA's *Constitution*, "The object of this  
39 Association shall be to encourage the improvement of the health of the public and to promote  
40 the art and science of dentistry." The Board believes that it is important for the strategic plan  
41 to expressly reflect this dual object in its new mission statement. *A Mission Statement is a*  
42 *statement of purpose-why does the ADA exist and what impact should it have.* Accordingly,  
43 the Board approved the following mission statement: "Help Dentists Succeed and Support  
44 the Advancement of the Health of the Public." The interests of the profession and the public  
45 truly share common ground. Likewise, the Board believes that the interests of our members  
46 and non-members share common ground. Only by converting non-members to membership  
47 will the ADA continue to thrive. Accordingly, the new mission statement embraces the  
48 concept of common ground as the basis for growth.  
49
- 50 • The Vision Statement: *A vision statement is a broad, aspirational statement that is not*  
51 *intended to be directly measurable. A vision statement represents our statement of a desired*

1 *end-state. It is a brief sentence describing a future state. The vision statement is both*  
2 *internal and external facing. It is intended to inspire and provide direction to members and*  
3 *staff. The ADA vision statement was approved by the Board last year. Since then, the Board*  
4 *received some limited feedback and adjusted the vision statement in light of that feedback.*  
5 *The vision statement is “Empowering the dental profession to achieve optimal health for all”.*  
6

- 7 • Core Values: *The core values statement is meant to reflect what we believe, and how we*  
8 *behave. It is a reflection of our culture. A core value is not created; it is discovered. It is not*  
9 *an aspirational statement but a test against which decisions need to be measured. The ADA*  
10 *already has a set of identified core values. Cognizant that core values are not supposed to*  
11 *be frequently changed, the Board has made only one change to those core values. The core*  
12 *values had included “diversity and inclusion” as a single value. The Board has now*  
13 *separated “inclusion” from “diversity” so that “inclusion” can have the same emphasis as*  
14 *“diversity”.*  
15
- 16 • Goals—Membership, Finance and Capacity: Under the structure of the strategic plan used  
17 by the ADA, *Goals are statements of desired outcomes-and priorities – they are neither*  
18 *specific nor measurable. The ADA’s current plan has three goals focused on membership,*  
19 *finance and capacity. The Board concluded that these three goals are truly foundational for*  
20 *our work. Without members, financial stability and the capacity to do the work of the*  
21 *Association, the ADA cannot succeed. Accordingly, the Board retained three goals focused*  
22 *on these areas as part of the next strategic plan.*  
23
- 24 • Goals—The Public Goal: In addition to membership, finance and capacity, the Board  
25 included a fourth goal, the public goal. This goal is needed to both recognize the dual  
26 Constitutional object of the Association and to implement the new mission statement. Based  
27 on the input received from the House and Council members, the Board was aware that strong  
28 feeling existed both in favor and against including a “public” goal to the next strategic plan.  
29 To bridge this divide, the Board followed the approach used in development of the new  
30 mission statement and looked for common ground between the interests of the member and  
31 the public. As is described below with respect to the objectives under this new goal, this  
32 common ground advances the interests of the profession and the public in a way that benefits  
33 both.  
34
- 35 • Objectives: Each of the four goals under *Common Ground 2025* has its own objectives.  
36 *Objectives are specific measurable statements of desired output. The objectives drive the*  
37 *Association toward meeting the broad goals of the plan. It is by looking at the objectives that*  
38 *the Association will know if it has achieved this next plan. The objectives for each goal are*  
39 *described below.*  
40
- 41 • Membership Goal Objectives: The Board has established four objectives under the  
42 membership goal, each of which focuses on an essential area to allow the ADA to grow.  
43 Objective 1 focuses on increasing membership in certain lagging demographics. Objective 2  
44 recognizes the limited role the national organization has in most individual membership  
45 decisions. It focuses on helping state societies advance membership. This particular  
46 objective blends well with the proposed plan’s capacity goal, discussed below. Objective 3  
47 focuses on retention. The ADA’s retention rate is excellent and maintaining that will be  
48 essential to the organization. Finally, objective 4 addresses the need to improve conversion  
49 rates across membership categories. A key example is the conversion from discounted new  
50 dentist rates to full dues-paying members. Each of the objectives is measurable and allows  
51 the Board to clearly monitor performance.  
52
- 53 • Finance Goal Targets: The finance goal maintains the target of total liquid reserves being no  
54 less than 50 percent of annual operating expenses. It also adds an objective on revenue.

The Board recognizes that the ADA must address both dues and non-dues revenue growth. Accordingly, the Board established a target of total revenue growth of 2-4 percent annually in order for the Association to remain strong.

- Organizational Capacity—State and National: In recent years, the ADA has placed an emphasis on aiding state societies in core capacity areas such as finance, governance and strategic planning, among other areas. The Board supports this emphasis and includes it in the proposed plan. In addition, the Board understands that ADA national staff must also be appropriately trained in order to assure that there is sufficient organizational capacity at both national and state levels to succeed.
- Organizational Capacity—ADA Subsidiaries: The role of ADA subsidiaries (and the ADA Foundation) was not explicitly addressed under the current plan and the Board concluded that it should be addressed in the next plan. Accordingly, the Board included objective 8 in the new plan, focusing on effectiveness and alignment. The success measure is tied to the subsidiaries' performance under their operating plans.
- The Public Goal Objectives: The new public goal has two objectives both of which highlight how building on common ground will advance the interests of BOTH the profession and the public. The first objective is that the ADA will be the preeminent driver of trusted oral health information for the public and the profession. The ADA has the unique resources to be the source of oral health information to both the public and the profession, as well as other stakeholders. By promoting this role, the ADA can serve both the profession and the public. The second objective is that dental benefit programs will be sufficiently funded and efficiently administered. Properly funded and administered dental benefit programs benefit both the public and the profession. The ADA already expends considerable resources advocating for such programs and working with members to address poorly funded or administered plans. In addition, research shows that appropriately funded benefit plans directly increase dental visits among beneficiaries (the public).
- Title and Term of Proposed Plan: Finally, the Board named the next plan, *Common Ground 2025*. As noted above, the reference to "Common Ground" is intended to reflect the conclusion that such common ground clearly exists on many important issues facing the Association. "2025" refers to the end of the proposed plan, January 1, 2025, making this a five year plan. Placing a date on the end of the plan is important to aid in implementation of Common Ground 2025 and the Board concluded that five years is an appropriate length, especially because the Board recognizes that the plan is a living document and should be adjusted as the organization moves forward.

**Plan Implementation:** An essential responsibility of the Board is to monitor and guide implementation of the strategic plan and to make and permit adjustments to the plan as work progresses. Under the proposed plan, the work of the Association will be able to move forward at an appropriate pace and the Board will be better able to monitor that work and intervene as needed to assure that adjustments are made. The objectives included in the plan will form the basis of reporting to the Board. In addition, in 2020, the Quarterly Management Report will be restructured based on the new plan. In a very visual way through the dashboard contained in that report, the Board will see which objectives seem to be working and which do not. This, combined with the narrative reports referenced above, will allow the Board to challenge staff, to seek further information and to ask for adjustments to the strategies being pursued. Of course, if circumstances warrant it, the Board will be free to adjust other aspects of the plan as well.

1 **Conclusion:** The Board is excited about the future of the ADA and knows that *Common Ground 2025*  
2 will help us to build a successful future.

3 **Resolutions**

4 This report is informational and no resolutions are presented.

5 **BOARD RECOMMENDATION: Vote Yes to Transmit.**

6  
7 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**  
8 **BOARD DISCUSSION)**

## Common Ground 2025: ADA Strategic Plan

**Mission Statement:** Help dentists succeed and support the advancement of the health of the public.

**Vision:** Empowering the dental profession to achieve optimal health for all.

**Core Values:**

- Commitment to members
- Integrity
- Excellence
- Commitment to the improvement of oral health
- Science/Evidence-based
- Diversity
- Inclusion

**MEMBERSHIP GOAL:** The ADA will have sufficient members to be the premier voice for oral health.

Objective 1: Increase membership market share of lagging demographics by 2% per year.

Objective 2: Maintain a net-positive gain in membership recruitment of all dentists within 70% or more of constituents.

Objective 3: Maintain an overall retention rate of 94%.

Objective 4: Increase overall average rates of conversion across membership categories by 1% per year.

**FINANCE GOAL:** The ADA will be financially sustainable.

Objective 5: Total revenue, including dues and non-dues, will increase by 2-4% annually.

Objective 6: Total unrestricted reserves will be targeted at no less than 50% of annual operating expenses.

**ORGANIZATIONAL GOAL:** All levels of the ADA will have sufficient organizational capacity necessary to achieve the goals of the strategic plan.

Objective 7: Improve overall organizational effectiveness at the national and state levels.

- 75% of constituents perform at least adequately (3 out of a scale of 5) in each capacity area.
- 75% of constituents have an average performance of more than adequate (4 out of a scale of 5) across all capacity areas.
- 20-30% of ADA staff are trained annually in targeted skill-based offerings.

Objective 8: Support organizational effectiveness and alignment of ADA subsidiaries.

- Subsidiary mission statements support ADA mission.
- Sufficient resources provided by ADA annually to assure 85% completion of subsidiary annual operating plans.
- Subsidiary service agreement performance measures are met by ADA.

**PUBLIC GOAL:** The ADA will support the advancement of the health of the public and the success of the profession.

Objective 9: The ADA will be the preeminent driver of trusted oral health information for the public and profession.

- Improve ADA's ranking as a trusted source of information for the public and key stakeholders.

Objective 10: Dental benefit programs will be sufficiently funded and efficiently administered.

- Improve dentist satisfaction with dental benefit programs.
- Increase the number of dental visits.

Resolution No. 36 NewReport: N/A Date Submitted: July 2019Submitted By: Council on Government AffairsReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None

Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_

Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

**PROPOSED POLICY, FEDERAL STUDENT LOAN PROGRAMS**

**Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policy entitled Advocacy for Graduate Student Loan Programs (*Trans.*2014:512). The Council concluded that the policy was relevant and reasonably current, but that it was worth amending to capture some of the newer proposals that Congress is considering to reform the Higher Education Act of 1965, which provides the statutory authority for most federal student loan programs to operate.

For example, the existing policy does not cover, among other things, proposals to privatize the current system of federal student loans, consolidate all graduate and undergraduate federal student loans into a one-fits-all program with a limited borrowing limit, and repealing regulations that were created to protect public student loan borrowers.

After consulting with the Council on Dental Education and Licensure, the Council on Government Affairs recommends that the following resolution entitled Federal Student Loan Programs be adopted:

**Resolution****Federal Student Loan Programs**

**36. Resolved,** that the American Dental Association supports the federal graduate and professional degree student loan programs authorized under the Higher Education Act of 1965, with an emphasis on:

1. Protecting access to federal Direct Unsubsidized Stafford Loans (Direct Loans) and Grad PLUS loans for graduate and professional degree students.
2. Reinstating eligibility for graduate and professional degree students to take advantage of federal Direct Subsidized Stafford Loans.
3. Removing annual and cumulative borrowing limits on federal student loans.
4. Lowering the interest rates and fees on federal student loans.
5. Capping total amount of interest that can accrue on federal student loans.
6. Halting the accrual of federal student loan interest while a dentist is completing a medical/dental internship or residency.
7. Extending the period of federal student loan deferment until after a new dentist has completed his or her medical/dental internship or residency.
8. Permitting federal graduate student loans to be refinanced more than once.

- 1 9. Simplifying and adding more transparency to the federal graduate student loan application
- 2 process.
- 3 10. Encouraging institutions of higher education and lenders to offer training to help students
- 4 make informed decisions about how to finance their graduate education.
- 5 11. Encouraging collaborative approaches to handling borrowers who fail (or are at risk of failing)
- 6 to fully repay their federal student loan(s) in the required time period.

7 and be it further

8 **Resolved**, that the ADA's position on allowing private lenders to have a role in the federal student  
9 loan program shall depend on whether the loan terms and conditions and borrower protections are  
10 guaranteed to be as favorable or better than the existing system of federal student loans, and be it  
11 further

12 **Resolved**, that the ADA supports strengthening federal regulations for the protection of all student  
13 loan borrowers, and be it further

14 **Resolved**, that the policy entitled Advocacy for Graduate Student Loan Programs (*Trans.*2014:512)  
15 be rescinded.

16 **BOARD RECOMMENDATION: Vote Yes.**

17 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**  
18 **BOARD DISCUSSION)**

**WORKSHEET ADDENDUM  
COUNCIL ON GOVERNMENT AFFAIRS  
ADA POLICY TO BE RESCINDED**

**Advocacy for Graduate Student Loan Programs (*Trans.2014:512*)**

**Resolved**, that the American Dental Association supports federal graduate student loan programs, with an emphasis on:

1. Minimizing and capping the interest rate(s) on federal graduate student loans;
2. Capping the total amount of interest on federal graduate student loans;
3. Allowing interest to accrue but not compound;
4. Enabling federal graduate student loans to be refinanced more than once to take advantage of the current interest rate(s) and economy;
5. Extending the period of deferment for repaying federal graduate student loans;
6. Expanding and enhancing the federal income tax deduction for student loan interest;
7. Providing a mechanism by which repayment can be earnings contingent;
8. Encouraging collaborative approaches to handling borrowers who fail (or at risk of failing) to fully repay their federal graduate student loan(s) in the required time period.

and be it further

**Resolved**, that the American Dental Association supports strengthening federal regulations for the protection of private student loan borrowers.

Resolution No. 37 NewReport: N/A Date Submitted: July 2019Submitted By: Council on Government AffairsReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

**PROPOSED POLICY, FEDERAL STUDENT LOAN REPAYMENT INCENTIVES**

**Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policies entitled Advocacy for Student Loan Forgiveness and Other Educational Debt Reduction Programs (*Trans.*2014:502) and Use of Federal and State Funds to Provide Loan Repayments to Dentists (*Trans.*1992:599; 2016:319).

The Council concluded that the policies were relevant and current, but also similar enough to warrant being merged into a single policy entitled Federal Student Loan Repayment Incentives.

After consulting with the Council on Dental Education and Licensure, the Council on Government Affairs recommends that the following resolution entitled Federal Student Loan Repayment Incentives be adopted:

**Resolution****Federal Student Loan Repayment Incentives**

**37. Resolved,** that the American Dental Association supports using state and federal funds to provide payments toward a dental professional's outstanding federal student loans in exchange for practicing in underserved areas, entering and remaining in public service and academic teaching and research positions, and filling other gaps in areas of national need, and be it further

**Resolved,** that the ADA supports removing barriers that prohibit those with private graduate student loans from taking advantage of state and federal student loan repayment programs, and be it further

**Resolved,** that the policies entitled Advocacy for Student Loan Forgiveness and Other Educational Debt Reduction Programs (*Trans.*2014:502) and Use of Federal and State Funds to Provide Loan Repayments to Dentists (*Trans.*1992:599; 2016:319) be rescinded.

**BOARD RECOMMENDATION: Vote Yes.****BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

**WORKSHEET ADDENDUM  
COUNCIL ON GOVERNMENT AFFAIRS  
ADA POLICIES TO BE RESCINDED**

**Use of Federal and State Funds to Provide Loan Repayments to Dentists (*Trans.1992:599*;  
*2016:319*)**

**Resolved**, that the American Dental Association supports the use of federal and state funds to provide loan repayment opportunities to dentists in return for service in recognized underserved communities or population groups.

**Advocacy for Student Loan Forgiveness and Other Educational Debt Reduction Programs  
(*Trans.2014:502*)**

**Resolved**, that the American Dental Association supports leveraging educational grants, scholarships, loan forgiveness, tax benefits, training opportunities, and other incentives to encourage dental professionals to practice in underserved areas, enter and remain in academic teaching and research positions, and fill other gaps in the nation's dental care infrastructure.

Resolution No. 38 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

## PROPOSED POLICY, TAX TREATMENT OF STUDENT LOAN INTEREST, SCHOLARSHIPS AND STIPENDS

**Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policies entitled Tax Deductibility of Interest on Health Profession Student Loans (*Trans.*1995:648) and Tax Exemptions for Scholarships and Stipends (*Trans.*1976:892).

The Council concluded that the policies were relevant and reasonably current, but similar enough to warrant being merged into a single policy entitled Tax Treatment of Student Loan Interest, Scholarships and Stipends.

After consulting with the Council on Dental Education and Licensure, the Council on Government Affairs recommends that the following resolution entitled Tax Treatment of Student Loan Interest, Scholarships and Stipends be adopted:

### Resolution

#### Tax Treatment of Student Loan Interest, Scholarships and Stipends

**38. Resolved**, that the American Dental Association supports the tax deductibility of interest on health profession student loans, and be it further

**Resolved**, that the ADA supports a tax exemption for scholarship assistance and stipends awarded to health professions students under federal programs, and be it further

**Resolved**, that the policies entitled Tax Deductibility of Interest on Health Profession Student Loans (*Trans.*1995:648) and Tax Exemptions for Scholarships and Stipends (*Trans.*1976:892) be rescinded.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

**WORKSHEET ADDENDUM  
COUNCIL ON GOVERNMENT AFFAIRS  
ADA POLICIES TO BE RESCINDED**

**Tax Deductibility of Interest on Health Profession Student Loans (*Trans.1995:648*)**

**Resolved**, that the American Dental Association supports the tax deductibility of interest on health profession student loans as a legislative priority.

**Tax Exemptions for Scholarships and Stipends (*Trans.1976:892*)**

**Resolved**, that the American Dental Association support legislation providing a tax exemption for scholarship assistance and stipends awarded to health professions students under federal programs.

Resolution No. 39 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

**PROPOSED POLICY, GENERAL, PEDIATRIC AND PUBLIC HEALTH DENTAL RESIDENCY PROGRAMS**

**Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policy entitled Advocacy for Dental Education Infrastructure (*Trans.*2014:502).

The Council concluded that the policy should be revised to more clearly reflect the original intent, which was to support the general, pediatric and public health dental residency programs authorized under Title VII of the Public Health Service Act. The Council also concluded that the second and third resolving clauses are unnecessary because they are addressed elsewhere in Association policy.

After consulting with the Council on Dental Education and Licensure, the Council on Government Affairs recommends that the following resolution entitled General, Pediatric and Public Health Dental Residency Programs be adopted:

**Resolution**

**General, Pediatric and Public Health Dental Residency Programs**

**39. Resolved,** that the American Dental Association supports using state and federal funds to support general, pediatric, and public health dental residency programs, including those authorized under Title VII of the Public Health Service Act, for dentists to obtain extended clinical training and experience in facilities that provide a disproportionate level of care to the underserved, and be it further

**Resolved,** that the policy entitled Advocacy for Dental Education Infrastructure (*Trans.*2014:502) be rescinded.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

**WORKSHEET ADDENDUM  
COUNCIL ON GOVERNMENT AFFAIRS  
ADA POLICY TO BE RESCINDED**

**Advocacy for Dental Education Infrastructure (*Trans.2014:502*)**

**Resolved**, that the ADA supports expanding and enhancing postgraduate general, pediatric, and public health dental residency programs for dentists to obtain extended clinical training and experience in facilities that provide a disproportionate level of care to the underserved, and be it further

**Resolved**, that the ADA supports expanding and enhancing incentives for dental school graduates to enter and remain in academic teaching and research positions, and be it further

**Resolved**, that state and local dental societies be urged to seek increased state appropriations for dental education.

Resolution No. 40 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

## **PROPOSED POLICY, NATIONAL PRETREATMENT STANDARD FOR DENTAL OFFICE WASTEWATER**

**Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policy entitled Negotiated Rulemaking Process Regarding a National Pretreatment Standard for Dental Office Wastewater (*Trans.*2010:602).

In 2010, the ADA House of Delegates adopted the policy entitled Negotiated Rulemaking Process Regarding a National Pretreatment Standard for Dental Office Wastewater (*Trans.*2010:602) to help mitigate the impact of an Environmental Protection Agency (EPA) regulation that would mandate the use of amalgam separators nationwide. The policy stipulated that the ADA's support was contingent on the EPA meeting nine conditions that the ADA considered fair, practical and science-based. The ADA worked with EPA for nearly a decade to ensure those conditions received a full and fair hearing.

In 2017, the agency issued a final rule that met all nine of the ADA's conditions, including adherence to the ADA's own Best Management Practices for Amalgam Waste. Dr. Gary L. Roberts, who was ADA president at the time, said in a statement that the rule was "a fair and reasonable approach to the management of dental amalgam waste" and "preferable to a patchwork of rules and regulations across various states and localities" (*Reports* 2017:47).

After revisiting the 2010 policy, the Council determined that the policy, as written, is obsolete given that the separator rule is no longer being negotiated. However, the Council also concluded that an amended version of the policy—one that retains the nine conditions for supporting the rule—is necessary to maintain the ADA's bargaining position should EPA ever consider revising the rule. Those conditions will also help the ADA work with EPA to help dentists comply.

The Council on Government Affairs recommends that the following resolution entitled National Pretreatment Standard for Dental Office Wastewater be adopted:

### **Resolution**

#### **National Pretreatment Standard for Dental Office Wastewater**

**40. Resolved,** that the following principles guide the American Dental Association's continued support for the Environmental Protection Agency's national pretreatment standard for dental office wastewater:

1. Any regulation should require covered dental offices to comply with best management practices patterned on the ADA's best management practices (BMPs), including the installation of International Organization for Standardization (ISO) compliant amalgam separators or separators equally effective.
2. Any regulation should defer to existing state or local law or regulation requiring separators so that the regulation would not require replacement of existing separators compliant with existing applicable law.
3. Any regulation should exempt dental practices that place or remove no or only de minimis amounts of amalgams.
4. Any regulation should include an effective date or phase-in period of sufficient length to permit affected dentists a reasonable opportunity to comply.
5. Any regulation should provide for a reasonable opportunity for covered dentists to repair or replace defective separators without being deemed in violation of the regulation.
6. Any regulation should minimize the administrative burden on covered dental offices by (e.g.) primarily relying upon self-certification (subject to verification or random inspection) and not requiring dental-office-specific permits.
7. Any regulation should not include a local numerical limit set by the local publicly owned treatment works (POTW).
8. Any regulation should not require wastewater monitoring at the dental office, although monitoring of the separators to assure proper operation may be required.
9. Any regulation should provide that compliance with it shall satisfy the requirements of the Clean Water Act unless a more stringent local requirement is needed.

and be it further

**Resolved**, that the policy entitled Negotiated Rulemaking Process Regarding a National Pretreatment Standard for Dental Office Wastewater (*Trans.2010:602*) be rescinded.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

**WORKSHEET ADDENDUM  
COUNCIL ON GOVERNMENT AFFAIRS  
ADA POLICY TO BE RESCINDED**

**Negotiated Rulemaking Process Regarding a National Pretreatment Standard for Dental Office Wastewater (*Trans.2010:602*)**

**Resolved**, that the appropriate agencies of the ADA engage the United States Environmental Protection Agency in a negotiated rulemaking process regarding a national pretreatment standard for dental office wastewater, and be it further

**Resolved**, that the following principles guide the Association's position in any negotiations with the United States Environmental Protection Agency:

1. Any regulation should require covered dental offices to comply with best management practices patterned on the ADA's best management practices (BMPs), including the installation of International Organization for Standardization (ISO) compliant amalgam separators or separators equally effective.
2. Any regulation should defer to existing state or local law or regulation requiring separators so that the regulation would not require replacement of existing separators compliant with existing applicable law.
3. Any regulation should exempt dental practices that place or remove no or only de minimis amounts of amalgams.
4. Any regulation should include an effective date or phase-in period of sufficient length to permit affected dentists a reasonable opportunity to comply.
5. Any regulation should provide for a reasonable opportunity for covered dentists to repair or replace defective separators without being deemed in violation of the regulation.
6. Any regulation should minimize the administrative burden on covered dental offices by (e.g.) primarily relying upon self certification (subject to verification or random inspection) and not requiring dental-office-specific permits.
7. Any regulation should not include a local numerical limit set by the local publicly owned treatment works (POTW).
8. Any regulation should not require wastewater monitoring at the dental office, although monitoring of the separators to assure proper operation may be required.
9. Any regulation should provide that compliance with it shall satisfy the requirements of the Clean Water Act unless a more stringent local requirement is needed. "

Resolution No. 41 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

# 1 PROPOSED POLICY, TAX TREATMENT OF EMPLOYER-PAID FRINGE HEALTH BENEFITS

2 **Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular  
3 Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association  
4 policy entitled Opposition to Taxation of Health Care Services and Fringe Benefits (*Trans.*1969:325;  
5 1982:549).

6 The Council concluded that the policy was written as a directive related to implementation—not a  
7 declarative policy statement—and was addressed and reported back to the HOD in 1983 (*Reports*  
8 1983:124, 125). The Council believes the subject matter is still relevant and should be retained the form  
9 of a declarative policy statement.

10 The Council on Government Affairs recommends that the following resolution entitled Tax Treatment of  
11 Employer-Paid Fringe Health Benefits be adopted:

## 12 Resolution

### 13 Tax Treatment of Employer-Paid Fringe Health Benefits

14 **41. Resolved,** that the American Dental Association is opposed to all forms of taxes on health care  
15 services, including employer-paid fringe health benefits, and be it further

16 **Resolved,** that the policy entitled Opposition to Taxation of Health Care Services and Fringe Benefits  
17 (*Trans.*1969:325; 1982:549) be rescinded.

18 **BOARD RECOMMENDATION: Vote Yes.**

19 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**  
20 **BOARD DISCUSSION)**

**WORKSHEET ADDENDUM  
COUNCIL ON GOVERNMENT AFFAIRS  
ADA POLICIES TO BE RESCINDED**

- 1  
2  
3  
4 **Taxes on Health Care Services (*Trans.*1969:325; 1982:549)**  
5 **Resolved**, that the American Dental Association, for the good and welfare of the public, go on record as  
6 being opposed to all forms of taxes on health care services including employer paid health fringe benefits.

Resolution No. 42 NewReport: N/A Date Submitted: July 2019Submitted By: Council on Government AffairsReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

**PROPOSED POLICY, TAX TREATMENT OF PROFESSIONAL DUES**

**Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policy entitled Tax Deductibility of Dues Paid to Professional Dental Organizations (*Trans.*1987:520).

The Council concluded that the policy was written as a directive related to implementation—not a declarative policy statement—and was reported back to the HOD in 1988 (see *Reports* 1988:143). The Council believes the subject matter is still relevant and should be retained in the form of a declarative policy statement.

The Council on Government Affairs recommends that the following resolution entitled Tax Treatment of Professional Dues be adopted:

**Resolution****Tax Treatment of Professional Dues**

**42. Resolved**, that the American Dental Association supports policies that would allow employed professionals to deduct certain professional expenses, such as the full amount of dues paid to professional organizations, from their income taxes,

and be it further

**Resolved**, that the policy entitled Tax Deductibility of Dues Paid to Professional Dental Organizations (*Trans.*1987:520) be rescinded.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

**WORKSHEET ADDENDUM  
COUNCIL ON GOVERNMENT AFFAIRS  
ADA POLICY TO BE RESCINDED**

**Tax Deductibility of Dues Paid to Professional Dental Organizations (*Trans.1987:520*)**

**Resolved**, that the American Dental Association, as a priority item, seek, in cooperation with other appropriate professional organizations, changes in the federal tax law to permit employed professionals to deduct the full amount of dues paid to their professional organizations as well as related professional expenses.

Resolution No. 43 NewReport: N/A Date Submitted: July 2019Submitted By: Council on Government AffairsReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

**AMENDMENT OF THE POLICY, LEGISLATIVE ASSISTANCE BY THE ASSOCIATION**

**Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policy entitled Legislative Assistance by the Association (*Trans.*1977:948; 1986:530).

The Council concluded that the first resolving clause is overly prescriptive given the evolving landscape of how the Association provides assistance to and works in partnership with its constituent and component societies. The Council also concluded that the second resolving clause is not necessary because it is related to implementation and not a declarative policy statement. It is self-evident that the Association would provide such assistance to its constituent and component societies.

The Council on Government Affairs recommends that the following resolution be adopted:

**Resolution**

**43. Resolved**, that the policy entitled Legislative Assistance by the Association (*Trans.*1977:948; 1986:530) be amended as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the American Dental Association, ~~its officers, staff, council, etc.~~ shall not assist in ~~any manner~~ any organization, agency, group or individual who is attempting to alter the laws of ~~the state of a constituent society~~ a state without the consent and approval of ~~that~~ the constituent society, ~~provided that upon request of a responsible agency or individual, copies of official policies of the American Dental Association, which are matters of public record, may be made available to such agency or individual, and be it further~~

**Resolved**, that ~~when the American Dental Association is aware of pending legislation within a state which is in opposition to existing Association policy or is otherwise detrimental to the best interests of the public, the Association shall inform the constituent society of the implications of such legislation, urge the constituent society to take appropriate action and offer assistance in addressing the issue.~~

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 44 NewReport: N/A Date Submitted: July 2019Submitted By: Council on Government AffairsReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None

Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_

Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

**AMENDMENT OF THE POLICY, INCLUSION OF MEMBERS OF CONGRESS IN HEALTH CARE LEGISLATION**

**Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policy entitled Inclusion of Members of Congress in Health Care Legislation (*Trans.*1993:718).

The Council concluded that the policy was written as a directive related to implementation—not a declarative policy statement—and was addressed and reported back to the HOD in in 1994 (see *Reports* 1994:112). However, the Council believes the subject matter is still relevant and should be retained the form of a declarative policy statement.

The Council on Government Affairs recommends that the following resolution be adopted:

**Resolution**

**44. Resolved**, that the policy entitled the policy entitled Inclusion of Members of Congress in Health Care Legislation (*Trans.*1993:718) be amended to read as follows (additions are underscored; deletions are ~~stricken~~):

**Resolved**, that the American Dental Association ~~communicate with other health care and public interest organizations the concept that~~supports including all members of Congress and all federal employees ~~must be included~~ in any comprehensive health care legislation passed for the population as a whole.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 46 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

# **RESCISSION OF THE POLICY, ENFORCEMENT OF STATE DENTAL PRACTICE ACTS**

**Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policy entitled Enforcement of State Dental Practice Acts (*Trans.*1976:921). The Council recommends rescinding the policy because it is no longer relevant to the current situation.

The policy was written as a directive related to implementation—not a declarative policy statement—and was addressed and reported back to the House of Delegates in 1977 (see *Reports* 1977:66). It was adopted to help state dental boards address a number of issues (e.g., insufficient staffing) that were preventing them from fully enforcing state dental practice acts in 1976 (*Trans.*1976:254). Those issues are not relevant in 2019.

The Council on Government Affairs recommends that the following resolution be adopted:

## **Resolution**

**46. Resolved,** that the policy entitled Enforcement of State Dental Practice Acts (*Trans.*1976:921) be rescinded.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

1                                   **WORKSHEET ADDENDUM**  
2                                   **COUNCIL ON GOVERNMENT AFFAIRS**  
3                                   **ADA POLICY TO BE RESCINDED**

4   **Enforcement of State Dental Practice Acts (*Trans.1976:921*)**

5   **Resolved**, that each constituent society, in consultation with its state board of dentistry, be urged to study  
6   the need for greater state support for enforcement of the state dental practice act, and be it further

7   **Resolved**, that, if need is established, the constituent society, in consultation with its state board of  
8   dentistry, consider developing mechanisms to obtain additional state support for enforcement of the state  
9   dental practice act in the public interest.

Resolution No. 47 New  
Report: NA Date Submitted: July 2019  
Submitted By: Council on Government Affairs  
Reference Committee: D (Legislative, Health, Governance and Related Matters)  
Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_  
Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_  
ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health  
How does this resolution increase member value: Not Applicable

1 **RESCISSION OF THE POLICY, FUNDING AND AUTHORITY FOR PATIENT PROTECTION**

2 **Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular  
3 Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association  
4 policy entitled Funding and Authority for Patient Protection (*Trans.*1983:560).

5 The Council recommends rescinding the policy because it was written as a directive related to  
6 implementation—not a declarative policy statement—and was addressed and reported back to the House  
7 of Delegates in 1984 (*Reports* 1984:137).

8 The Council on Government Affairs recommends that the following resolution be adopted:

9 **Resolution**

10 **47. Resolved,** that the policy entitled Funding and Authority for Patient Protection (*Trans.*1983:560)  
11 be rescinded.

12 **BOARD RECOMMENDATION: Vote Yes.**

13 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**  
14 **BOARD DISCUSSION)**

1                                   **WORKSHEET ADDENDUM**  
2                                   **COUNCIL ON GOVERNMENT AFFAIRS**  
3                                   **ADA POLICY TO BE RESCINDED**

4   **Funding and Authority for Patient Protection (*Trans.*1983:560)**

5   **Resolved**, that constituent dental societies be encouraged to lobby legislatures to provide additional state  
6   dental board funding and authority for patient protection activities.

Resolution No. 57 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

# 1                                   **RESCISSION OF THE POLICY, STANDARD BENEFIT PACKAGE**

2   **Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular  
3 Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association  
4 policy entitled Standard Benefit Package (*Trans.*1993:665).

5 The Council recommends rescinding the policy because it is written as a directive related to  
6 implementation—not a declarative policy statement—and was addressed and reported back to the House  
7 of Delegates in 1994 (*Reports* 1994:109).

8 The Council noted that the policy was adopted specifically to guide the ADA's advocacy on health care  
9 reform proposals made during the Clinton era. The landscape of health care law and regulation is much  
10 different than it was in the early 1990s.

11 The Council on Government Affairs recommends that the following resolution be adopted:

## 12   **Resolution**

13       **57. Resolved**, that the policy entitled Standard Benefit Package (*Trans.*1993:665) be rescinded.

14 **BOARD RECOMMENDATION: Vote Yes.**

15 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**  
16 **BOARD DISCUSSION)**

**WORKSHEET ADDENDUM  
COUNCIL ON GOVERNMENT AFFAIRS  
ADA POLICY TO BE RESCINDED**

**4 Standard Benefit Package (*Trans.1993:665*)**

**5 Resolved,** that the American Dental Association supports inclusion of a basic medical-surgical-hospital  
**6** benefits plan, subject to a deductible, in legislation addressing health system reform.

Resolution No. 59 New  
Report: N/A Date Submitted: July 2019  
Submitted By: Council on Government Affairs  
Reference Committee: D (Legislative, Health, Governance and Related Matters)  
Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_  
Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_  
ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health  
How does this resolution increase member value: Not Applicable

1 **RESCISSION OF THE POLICY, STATE RESPONSIBILITY FOR HEALTH, SAFETY AND WELFARE**

2 **Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular  
3 Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association  
4 policy entitled State Responsibility for Health, Safety and Welfare (*Trans.*1978:530). The Council  
5 concluded that the policy is redundant and should be rescinded.

6 This policy is nearly identical to the policy entitled States' Rights Affecting the Practice of Dentistry  
7 (*Trans.*1995:649; 1996:715), which states that the ADA "supports the authority of each state government  
8 to adopt and enforce laws and rules that regulate the practice of dentistry and enhance the oral health of  
9 the public within its jurisdiction."

10 The Council on Government Affairs recommends that the following resolution be adopted:

11 **Resolution**

12 **59. Resolved,** that the policy entitled State Responsibility for Health, Safety and Welfare  
13 (*Trans.*1978:530) be rescinded.

14 **BOARD RECOMMENDATION: Vote Yes.**

15 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**  
16 **BOARD DISCUSSION)**

**WORKSHEET ADDENDUM  
COUNCIL ON GOVERNMENT AFFAIRS  
ADA POLICY TO BE RESCINDED**

**State Responsibility for Health, Safety and Welfare (*Trans.*1978:530)**

**Resolved**, and reaffirmed, that the constitutional responsibility for the health, safety and welfare of the citizens of each respective state is the responsibility of each state and that state alone, and should not be abrogated, and be it further

**Resolved**, that the ADA does constantly reflect these feelings in their dealings with political leaders in all areas of government, and be it further

**Resolved**, that each dentist through his or her every area of influence do all in his or her power to preserve this constitutional responsibility and right.

Resolution No. 61 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

1 **RESCISSION OF THE POLICY, TESTIMONY BY COMPONENT AND CONSTITUENT SOCIETIES**

2 **Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular  
3 Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association  
4 policy entitled Testimony by Component and Constituent Societies (*Trans.*1979:637).

5 The Council concluded that the policy is unnecessary because it is inherent in the ADA Constitution and  
6 many ADA policies that the Association provide such technical assistance to constituent and component  
7 dental societies. It is reason the Department of State Government Affairs even exists. A policy reiterating  
8 this foundational responsibility is not necessary.

9 The Council on Government Affairs recommends that the following resolution be adopted:

10 **Resolution**

11 **61. Resolved,** that the policy entitled Testimony by Component and Constituent Societies  
12 (*Trans.*1979:637) be rescinded.

13 **BOARD RECOMMENDATION: Vote Yes.**

14 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**  
15 **BOARD DISCUSSION)**

1                                   **WORKSHEET ADDENDUM**  
2                                   **COUNCIL ON GOVERNMENT AFFAIRS**  
3                                   **ADA POLICY TO BE RESCINDED**

4   **Testimony by Component and Constituent Societies (*Trans.1979:637*)**

5   **Resolved**, that the ADA encourage its component and constituent societies to give public testimony on  
6   dentally related issues at regional hearings of congressional committees when such opportunities are  
7   available, and be it further

8   **Resolved**, that the ADA staff inform the component and constituent societies of such opportunities, and  
9   be it further

10   **Resolved**, that the ADA staff assist component and constituent societies with background material to  
11   develop such testimony.

Resolution No. 63 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Government Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

**RESCISSION OF THE POLICY, COOPERATION OF ADA AND CONSTITUENT SOCIETIES IN  
DEVELOPMENT OF STATE HEALTH CARE REFORM**

**Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policy entitled Cooperation of ADA and Constituent Societies in Development of State Health Care Reform (*Trans.*1995:652).

The Council recommends rescinding the policy because it is not a declarative policy statement. Rather, it is all that remains of a 1993 directive related to implementation that was addressed and reported back to the House of Delegates in 1994 (*Reports* 1994:110). There is no explanation about why this single resolving clause was retained.

It is inherent in the ADA Constitution and many ADA policies that the Association provide such assistance to constituent and component dental societies on a regular basis. A policy reiterating this foundational responsibility is not necessary.

The Council on Government Affairs recommends that the following resolution be adopted:

**Resolution**

**63. Resolved,** that the policy entitled Cooperation of ADA and Constituent Societies in Development of State Health Care Reform (*Trans.*1995:652) be rescinded.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

**WORKSHEET ADDENDUM  
COUNCIL ON GOVERNMENT AFFAIRS  
ADA POLICY TO BE RESCINDED**

**Cooperation of ADA and Constituent Societies in Development of State Health Care Reform  
(*Trans.1995:652*)**

**Resolved**, that the ADA work closely with constituent societies to monitor and participate, upon the invitation of the constituent society, in any development of health care reform on the state level.

Resolution No. 70 NewReport: N/A Date Submitted: July 2019Submitted By: Council on Ethics, Bylaws and Judicial AffairsReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

**REPORT ON THE REFERRAL OF RESOLUTION 21H-2018: AMENDMENT OF POLICY: USE OF THE TERM "SPECIALTY"**

**Background:** In accord with Resolution 170H-2012, Regular Comprehensive Policy Review (*Trans.* 2012:370), the Council on Dental Education and Licensure (CDEL) reviewed the Association's policies related to the dental specialties in 2018, including the policy entitled *Use of the Term "Specialty,"* which states:

**Use of the Term "Specialty" (*Trans.*1957:360)**

**Resolved,** that the use of the term "specialty" by any group which does not represent a specialty formally recognized by the American Dental Association be disapproved.

Believing that this policy is outdated because the recognition of dental specialties is now within the purview of the National Commission on Recognition of Dental Specialties and Certifying Boards (not the ADA), and because the statement is contrary to Section 5.H. of the ADA *Principles of Ethics and Code of Professional Conduct*, Announcement of Specialization and Limitation of Practice, CDEL recommended rescission of the policy.

The 2018 House of Delegates did not rescind the policy; rather, the House referred the resolution for further study and a report to the 2019 House of Delegates. The referral has been assigned to the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). Subsequently, a small working group of CEBJA and CDEL members was convened to collaborate and further study the policy in question.

**Discussion:** There is no doubt that the policy entitled "Use of the Term Specialty" must be revised. As presently written, the policy does not recognize two recent fundamental revisions on dental specialty recognition and announcement approved by the House of Delegates and upon which CDEL relied in recommending rescission last year:

- The American Dental Association no longer recognizes dental specialties. The responsibility to recognize dental specialties (and certifying boards for dental specialties) now falls on the National Commission on Recognition of Dental Specialties and Certifying Boards (NCRDSCB) (*Trans.*2017:250).
- Section 5.H. of the ADA *Principles of Ethics and Code of Professional Conduct* was amended in 2017 to recognize that states may exercise the authority to recognize areas of practice as dental specialties that have not been formally recognized as such by the ADA (now the NCRDSCB)

(*Trans.*2016:341). Consequently, policy limiting use of the term “specialist” only to those specialties approved by the NCRDSCB is too limiting and out of date.

Following its study of this issue, rather than recommending rescission of the policy, the CEBJA/CDEL working group recommended amendment of the policy so that it (1) aligns with the responsibility of NCRDSCB to recognize specialties and (2) also acknowledges that jurisdictions may use means other than reliance on NCRDSCB recognition in allowing practitioners to announce as specialists within their borders. Both CEBJA and CDEL concur with the working group’s recommendation. Consequently, the following resolution is proposed for consideration by the House of Delegates:

### Resolution

**70. Resolved**, that the ADA policy entitled “Use of the Term ‘Specialty’” (*Trans.*1957:360) be amended as follows (additions underscored, deletions ~~stricken through~~):

**Resolved**, that the use of the term “specialty” be reserved for those by any groups which that does not represent a dental specialties specialty formally recognized by the American Dental Association-National Commission on Recognition of Dental Specialties and Certifying Boards and/or groups accepted as specialties in the jurisdictions in which they practice ~~be disapproved~~.

**BOARD RECOMMENDATION: Vote Yes.**

**Vote: Resolution 70**

BLACK	Yes	GEHANI	Yes	KLEMMEDSON	Yes	RODRIGUEZ	Yes
COHLMIA	Yes	HARRINGTON	Yes	KYGER	Yes	SABATES	Yes
DOROSHOW	No	HERRE	Yes	LEARY	Yes	SHEPLEY	Yes
EDGAR	Yes	HIMMELBERGER	Yes	MCDUGALL	Yes	STEPHENS	Yes
FISCH	Yes	HUOT	Yes	NORBO	Yes	THOMPSON	Yes

Resolution No. 71 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

## 1 **AMENDMENT OF CHAPTER V., SECTION E.2. OF THE GOVERNANCE MANUAL – PILOT** 2 **PROGRAMS**

3 **Background:** In 2015, the House of Delegates adopted Resolution 41H-2015 (*Trans.*2015:291), a  
4 proposal from the Board of Trustees. The stated purpose of the resolution was to allow the ADA to  
5 conduct pilot projects which would otherwise violate some provision of the *Bylaws*. This was needed to  
6 allow testing of new ideas without first amending the *Bylaws*. The Board recognized that it would be  
7 desirable to provide supervision over the Board's exercise of this authority and that pilot projects which  
8 would otherwise violate the *Bylaws* should be limited in scope and duration.

9 Report 5 of the Board of Trustees in 2015 stated it this way:

10 Accordingly, the Board is proposing a *Bylaws* amendment that will authorize it to conduct pilot  
11 programs, of limited duration and scope (e.g., geographic or demographic) and with reporting to the  
12 House, which would otherwise contravene some other provision of the *Bylaws*.

13 Resolution 41H was approved on consent by the 2015 House of Delegates. No changes were made to it  
14 by the Reference Committee or the House as a whole.

15 **Discussion:** Through an oversight, the approved resolution did not accurately mirror the description of  
16 the pilot program authority as stated in the Board report. Specifically, the key qualifier applicable to pilot  
17 programs subject to the reporting requirement—that the pilot otherwise contravened some other provision  
18 of the *Bylaws*—was not included in the resolution.\* The proposed amendment offered here is simply to  
19 correct this oversight and to make clear that the reporting obligation extends to only those pilot projects  
20 which contravene some *Bylaws* provision.

21 This is an important clarification because, since 2015, the Association has begun employing an Agile  
22 project management methodology whereby any new initiative of any size or importance is tested,  
23 assessed and adjusted or abandoned as necessary. Accordingly, under a common understanding of  
24 “pilot” (i.e., developmental, experimental, trial), almost everything the ADA undertakes can be thought of  
25 as a pilot program. The Council's proposal serves to clarify what was explicitly intended to be the case in

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\* Resolution 41H-2015 provides: “...Notwithstanding any other provision in the *Bylaws*, authorize pilot programs of limited scope ...”

The phrase “notwithstanding any other provision in the *Bylaws*” was intended to address this but is, at best, ambiguous.

the background statement of Board Report 5 of 2015: only those pilot projects that contravene the *Bylaws* are subject to the annual reporting requirement found in Resolution 41H-2015.

And, of course, the Board and Councils already report to the House on developments of significance and this proposed *Bylaws* amendment does nothing to alter that.

Accordingly, the Council offers the following resolution for the House's consideration:

### Resolution

**71. Resolved**, that Chapter V., Section E.2. of the Governance Manual of the American Dental Association be amended as indicated (additions underscored):

#### CHAPTER V. BOARD OF TRUSTEES

\* \* \*

#### E. Powers

\* \* \*

2. Consistent with the exercise of its power to authorize limited scope pilot programs, approve guidelines relating to the conduct of the program when authorizing a pilot program. No pilot program authorized by the Board of Trustees shall exceed a period of three years without approval by the House of Delegates. The Board of Trustees shall annually report to the House of Delegates on any authorized pilot program during the program's duration that is inconsistent with any provision of the *Bylaws*.

**BOARD RECOMMENDATION: Vote Yes.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. 73 New

Report: N/A Date Submitted: July 2019

Submitted By: Council on Ethics, Bylaws and Judicial Affairs

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

## 1 **AMENDMENT OF THE ADA BYLAWS AND GOVERNANCE MANUAL TO REVISE THE COMMITTEE** 2 **STRUCTURE OF THE ADA**

3 **Background:** The Speaker of the House of Delegates requested that the Council on Ethics, Bylaws and  
4 Judicial Affairs undertake a review of the ADA *Bylaws* and the *Governance Manual of the American*  
5 *Dental Association* (“*Governance Manual*”) relating to the selection and appointment of members to  
6 committees (sometimes referred to as “standing committees”), special committees and subcommittees.  
7 Following its initial review, the Council determined that it would be of assistance to the volunteer  
8 leadership of the Association to amend the *Bylaws* and *Governance Manual* to more clearly define and  
9 delineate the difference between committees, special committees and subcommittees and to collect in  
10 one place the provisions governing the establishment and operation of those bodies. Thus, the Council is  
11 proposing deletion of the current Chapter X. of the *Bylaws* and substituting the rewritten *Bylaws* Chapter  
12 X. in its place.

13 **Analysis:** In reviewing this issue at the request of the Speaker of the House of Delegates, some  
14 inconsistencies in the *Bylaws* were noted. For example, Chapter X. of the *Bylaws* states that “the  
15 appointment of the members of a special committee, their number, tenure and funding shall be set forth in  
16 the resolution creating such committee.” But Section 110.B. of Chapter III. of the *Bylaws* states that “[t]he  
17 composition of special committees formed by the House of Delegates shall be determined by the Speaker  
18 of the House of Delegates” which appears to be contrary to the language of *Bylaws* Chapter X.

19 In addition, ADA policy defines a special committee as one that will “cease to exist when its assigned task  
20 is completed or with the adjournment *sine die* of the annual session of the House of Delegates following  
21 its creation” (Definitions of Committees (*Trans.*2001:447; 2013:340; 2018:73). Given that a special  
22 committee is in existence for a year or less, it appears unnecessary that the tenure of committee  
23 members to be specified, as currently required in Section 110.B. of Chapter III. of the *Bylaws*.

24 Also, the resolution presented proposes amendments to several other areas of the *Bylaws* and  
25 *Governance Manual* to harmonize those provisions with the proposed new Chapter X. In the current  
26 Bylaws, Chapter V. Board of Trustees, Section 70. Powers, subsection K. states, in part, that the Board  
27 has the power to appoint its members to committees. Adoption of the proposed amendment to Chapter  
28 X. of the *Bylaws* would render that portion of Chapter V., Section 70.k. redundant. Consequently, the  
29 proposed resolution provides for a rewritten Section 70.k. to Chapter V. of the *Bylaws*. The resolution  
30 also amends Section 110 of Chapter III. of the *Bylaws* and Chapter III. of the *Governance Manual* to  
31 harmonize those provisions with the provisions of newly rewritten *Bylaws* Chapter X.

Finally, adoption of the proposed new version of Chapter X. of the *Bylaws* would render the ADA policy entitled "Definition of Committees" (*Trans.*2001:447; 2013:340; 2018:73) superfluous. As a result, the resolution presented calls for that policy to be rescinded.

In light of the foregoing, the following resolution is proposed for consideration by the House of Delegates:

### Resolution

**73. Resolved**, that Chapter X. SPECIAL COMMITTEES of the ADA *Bylaws* be stricken in its entirety and replaced by a new CHAPTER X., entitled COMMITTEES, SPECIAL COMMITTEES AND SUBCOMMITTEES, as set forth below (additions underscored):

#### **CHAPTER X • COMMITTEES, SPECIAL COMMITTEES AND SUBCOMMITTEES**

Section 10. COMMITTEES. A committee is a group having ongoing duties, assignments or responsibilities that are specified in the *Bylaws* or the *Governance Manual* or has duties delegated to it by the agency establishing the committee.

A. ESTABLISHMENT AND DUTIES. The House of Delegates and Board of Trustees may establish committees. The resolution establishing a committee shall specify duties and scope of responsibility of the committee, which thereafter shall be set forth in the rules of the body establishing the committee.

B. MEMBERSHIP AND MEMBER APPOINTMENT, TERM AND TENURE. The resolution establishing a committee shall specify the number and type of committee members and their term, tenure and method of selection, which thereafter shall be set forth in the rules of the body establishing the committee. If a committee is delegated duties otherwise assigned to the Board of Trustees, a majority of the members of the committee shall be members of the Board of Trustees.

C. RULES OF OPERATION. The rules of operation and procedures of committees shall be as set forth in the *Governance Manual* and the rules of body establishing the committee.

D. FUNDING. Unless otherwise specified in the resolution establishing a committee, any funding required by the committee to fulfill its duties and responsibilities shall be the responsibility of the body establishing the committee.

E. REPORTING. All reports of a committee shall be directed to the body that established the committee.

F. PRIVILEGE OF THE FLOOR. Chairs and members of committees who are not members of the House of Delegates shall have the right to participate in the debate on any reports originating with their respective committees but shall have no other rights unless that person is a duly credentialed delegate or alternate delegate.

Section 20. SPECIAL COMMITTEE. A special committee is a group formed to perform tasks not otherwise assigned by the *Bylaws* or the *Governance Manual*. A special committee will cease to exist at the earlier of the completion of its assigned tasks or at the adjournment *sine die* of the annual session of the House of Delegates following its creation.

A. ESTABLISHMENT AND DUTIES. The House of Delegates, Board of Trustees and councils and commissions of the ADA may establish special committees. The resolution or motion establishing a special committee shall specify the tasks and scope of responsibility assigned to the special committee.

B. MEMBERSHIP AND MEMBER APPOINTMENT, TERM AND TENURE. The resolution or motion establishing a special committee shall specify the number and type

of committee members, their method of selection and the term and tenure of members of the Committee.

C. RULES OF OPERATION. The rules of operation and procedures of special committees shall be as set forth in the *Governance Manual* and the rules of body establishing the special committee.

D. FUNDING. Unless otherwise specified in the resolution or motion establishing a special committee, any funding required by the special committee to fulfill its assigned tasks shall be the responsibility of the body establishing the special committee.

E. REPORTING. All reports of a special committee shall be directed to the body that established the committee.

F. PRIVILEGE OF THE FLOOR. Chairs and members of special committees who are not members of the House of Delegates shall have the right to participate in the debate on any reports originating with their respective special committees but shall have no other rights unless that person is a duly credentialed delegate or alternate delegate.

Section 30. SUBCOMMITTEE. A subcommittee is a subgroup of a body created for a specific purpose within the jurisdiction of the creating body. It may have authority delegated to it by the creating body.

A. ESTABLISHMENT AND DUTIES. Committees of the House of Delegates, committees of the Board of Trustees and councils and commissions of the ADA may establish subcommittees. The resolution or motion establishing a subcommittee shall specify the tasks and scope of responsibility assigned to the subcommittee.

B. MEMBERSHIP AND MEMBER APPOINTMENT, TERM AND TENURE. Members of a subcommittee shall be limited to members of the body establishing the subcommittee. The resolution or motion establishing a subcommittee shall specify the number of members and their method of selection.

C. RULES OF OPERATION. The rules of operation and procedures of subcommittee shall be the same as the body that established the subcommittee, unless otherwise specified in the *Governance Manual* or the rules of body that established the special committee.

D. FUNDING. Any funding required by the subcommittee to fulfill its assigned tasks shall be the responsibility of the body establishing the subcommittee.

E. REPORTING. All reports of a subcommittee shall be directed to the body that established the subcommittee.

and be it further

**Resolved**, that the title of CHAPTER X. of the *Governance Manual* be revised as shown below (additions underscored):

#### **CHAPTER X. COMMITTEES, SPECIAL COMMITTEES AND SUBCOMMITTEES**

and be it further

**Resolved**, that CHAPTER III. HOUSE OF DELEGATES, Section 110. COMMITTEES of the *Bylaws* be amended as follows (deletions ~~stricken through~~):

#### **CHAPTER III • HOUSE OF DELEGATES**

\* \* \*

Section 110. COMMITTEES:

1 ~~A. STANDING COMMITTEES.~~ The standing committees of the House of Delegates shall be  
2 the Committee on Constitution and Bylaws, the Committee on Credentials, Rules and Order  
3 and such Reference Committees as shall in the determination of the Speaker of the House of  
4 Delegates be necessary to complete the business of the House of Delegates. ~~The~~  
5 ~~composition and duties of the standing committees of the House of Delegates shall be as~~  
6 ~~stated in the Manual of the House of Delegates.~~

7 ~~B. SPECIAL COMMITTEES.~~ The composition of special committees formed by the House of  
8 Delegates shall be determined by the Speaker of the House of Delegates. The duties of any  
9 special committee shall be as specified by the House of Delegates, but may only include  
10 duties not otherwise assigned by these Bylaws. Any special committee created by the House  
11 of Delegates shall exist until the duties assigned to it are fulfilled or until adjournment sine die  
12 of the House of Delegates session immediately following the session at which it was  
13 appointed, whichever first occurs.

14 and be it further

15 **Resolved**, that CHAPTER V. BOARD OF TRUSTEES, Section 70. POWERS, Subsection K. be  
16 amended as shown below (deletions ~~stricken through~~, additions underlined):

17 **CHAPTER V • BOARD OF TRUSTEES**

18 \* \* \*

19 *Section 70. POWERS:* The Board of Trustees shall be the managing body of the Association,  
20 vested with power to:

21 \* \* \*

22 K. ~~Appoint its members to committees that shall have the power to perform any duty that the~~  
23 ~~Board of Trustees may lawfully delegate.~~ Delegate any of its duties that can be lawfully  
24 delegated to one or more committees of the Board of Trustees.

25 and be it further

26 **Resolved**, that the ADA policy entitled Definitions of Committees (*Trans.*2001:447; 2013:340;  
27 2018:359) be rescinded.

28 **BOARD RECOMMENDATION: Vote Yes.**

29 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**  
30 **BOARD DISCUSSION)**

**WORKSHEET ADDENDUM  
ADA POLICIES TO BE RESCINDED**

**Definitions of Committees ( *Trans.*2001:447; 2013:340; 2018:359)**

**Resolved**, that the American Dental Association accepts the following definitions for the terms standing committee, special committee and subcommittee:

Standing committee—A standing committee is a group of members whose work, assignments, or tasks are ongoing. A standing committee performs any work within its particular field either assigned to it by the *Bylaws* or referred to it by the House of Delegates or Board of Trustees.

Special committee (also known as a Task Force)—A special committee or task force is a group of members created by the House of Delegates or, when the House is not in session, by the Board of Trustees. It will perform specific tasks not otherwise assigned by the *Bylaws*. A special committee will cease to exist either when its assigned task is completed or with the adjournment *sine die* of the annual session of the House of Delegates following its creation.

Subcommittee—A subcommittee is a subgroup of a body created for a specific purpose within the jurisdiction of that body. It may have authority delegated to it by the body, and which reports and is responsible to only the delegating body. A delegating body may be a council, committee or commission.

Resolution No. 77 New

Report: N/A Date Submitted: July 2019

Submitted By: Dr. James D. Nickman, Delegate, Minnesota

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

## 1 DENTAL SPECIALTIES REPRESENTATION IN HOUSE OF DELEGATES

2 The following resolution was submitted on July 30, 2019, by Dr. James D. Nickman, delegate, Minnesota.

3 **Background:** Medical specialty societies have representative delegates within organized medicine,  
4 including each specialty having at least one delegate and one alternative delegate in the American  
5 Medical Association's House of Delegates, and each AOA recognized specialty college having at least  
6 one delegate and one alternate delegate in the American Osteopathic Association's House of Delegates.  
7 Also, the American Dental Education Association has included representatives from the recognized  
8 dental specialties in the ADEA House of Delegates.

9 The current structure of the American Dental Association House of Delegates represents the 53  
10 constituent societies, the five federal dental services and the American Student Dental Association.

11 However, the dental specialties currently recognized by the independent National Commission on  
12 Recognition of Dental Specialties and Certifying Boards as represented by their recognized national  
13 dental specialty organizations (American Academy of Pediatric Dentistry, American Academy of  
14 Periodontology, American Academy of Oral and Maxillofacial Pathology, American Academy of Oral and  
15 Maxillofacial Radiology, American Association of Endodontists, American Association of Orthodontists,  
16 American Association of Oral and Maxillofacial Surgeons, American Association of Public Health  
17 Dentistry, American College of Prosthodontists, and American Society of Dentist Anesthesiologists) have  
18 no specifically dedicated representation in the ADA House of Delegates.

19 Those delegates and alternate delegates of the American Dental Association who are dental specialists  
20 are selected by constituent societies and are under no obligation or directive to represent the principles or  
21 policies of the national dental specialty organizations to which they may belong.

22 Each dental specialty brings a unique set of knowledge and experience to enhance the profession of  
23 dentistry and advance the health and safety of patient populations. National dental specialty  
24 organizations representing the dental specialties currently recognized by the independent National  
25 Commission on Recognition of Dental Specialties and Certifying Boards establish principles and policies  
26 to support and advance unique sets of knowledge and experience to enhance the profession of dentistry  
27 and advance the health and safety of patient populations, and designated representatives of such  
28 national dental specialty organizations in the American Dental Association House of Delegates shall  
29 advance the same. This further strengthens the American Dental Association as a leader and advocate  
30 in oral health.

Neither the American Dental Association House of Delegates, nor current or future representatives thereof, have the authority to recognize dental specialties or approve or deny any application for dental specialty. This resolution is not intended to prohibit or restrict in any way, any dental specialty recognized, now or in the future, by the National Commission on Recognition of Dental Specialties and Certifying Boards, or any dental specialty as recognized in any other areas of dentistry for which specialty recognition has been granted under the standards required or recognized in the practitioner's jurisdiction, from seeking representation in the American Dental Association House of Delegates.

**Funding:** Each dental specialty will pay for travel and lodging of their delegate and alternate.

In light of the foregoing, it is recommended that the following resolution be adopted:

#### Resolution

**77. Resolved,** that Chapter III, House of Delegates, Section 10 (Members), Subsection A (Voting Members) of the ADA *Bylaws* be amended as follows (additions underlined, deletions ~~stricken~~):

"A. VOTING MEMBERS. The voting members of the House of Delegates shall be composed of officially certified delegates of the constituents and of the federal dental services, who shall be active, life or retired members, ~~and~~ officially certified delegates of the American Student Dental Association, and officially certified delegates of dental specialties recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards who shall be active, life or retired members.

and be it further

**Resolved,** that Chapter III, House of Delegates, Section 10 (Members), Subsection B (Alternate Delegates) of the ADA *Bylaws* be amended as follows (additions underlined, deletions ~~stricken~~):

B. ALTERNATE DELEGATES. Each constituent and each federal dental service may select from among its active, life or retired members up to the same number of alternate delegates as delegates. The American Student Dental Association may select from among its active members up to the same number of alternate delegates as delegates. Each dental specialty recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards may select from among its active, life or retired members an alternate delegate.

and be it further

**Resolved,** that Chapter III, House of Delegates, Section 10 (Members), Subsection D (Election or Selection) of the ADA *Bylaws* be amended as follows (additions underlined, deletions ~~stricken~~):

D. ELECTION OR SELECTION. A constituent's delegates shall be elected or, in the case of a constituent's alternate delegates elected or selected by one or more of the following methods:

1. By the membership at large of that constituent;
2. By the constituent's governing legislative body, House of Delegates, or Board of Directors, or in the case of alternate delegates, at the discretion of the constituent; or
3. By a component with respect to delegates representing that component.

Each federal dental services and the American Student Dental Association may establish its own method for selecting or selecting delegates, except that the American Student Dental Association shall select its five (5) delegates from its even number regions in even numbered years, and the odd numbered regions in odd numbered years, with their alternate delegates

1           selected from the opposite groups of regions. Each national dental specialty organization  
2           recognized by the National Commission on Recognition of Dental Specialties and Certifying  
3           Boards shall establish its own method for electing or selecting its delegate and alternate  
4           delegate.

5           and be it further

6           **Resolved**, that Chapter III, House of Delegates, Section 30 (Representation) of the ADA *Bylaws* be  
7           amended as follows (additions underlined, deletions ~~stricken~~):

8           Section 30. REPRESENTATION. Each constituent society, each federal dental service and the  
9           American Student Dental Association shall be entitled to representation as set forth in the Manual of  
10          the House of Delegates. Each dental specialty recognized by the National Commission on  
11          Recognition of Dental Specialties and Certifying Boards shall be entitled to one delegate and one  
12          alternate, which are not included in the representation formula as set forth in the section entitled  
13          Representation of Constituents and Periodic Reapportionment of Delegates and Alternate Delegates  
14          found in the Manual of the House of Delegates. The House of Delegates may, by a two-thirds (2/3)  
15          vote of the delegates present and voting suspend the representation of a constituent in the House of  
16          Delegates upon a determination by the House that the constitution or bylaws of the constituent  
17          conflicts or limits the Constitution or Bylaw of this Association. Such suspension shall not be effective  
18          until the House of Delegates has voted that the constituent is in violation and has one year after  
19          notification of the specific violation to correct its constitution or bylaws.

20          **BOARD COMMENT:** The Board thanks the delegate for submitting the resolution, but the Board does  
21          not support expanding the size of the House.

22          Dental specialists already have a robust presence in the ADA House of Delegates. In the 2018 House of  
23          Delegates, 100 out of 483 delegates, or 20.70% were identified as specialists. ADA data shows that the  
24          current participation by specialists in the House of Delegates virtually precisely matches the proportion of  
25          specialists in the universe of licensed dentists (42,615 specialists out of 201,049 licensed dentists, or  
26          20.78%). Moreover, each of the nine specialties recognized in 2018 had at least one member of their  
27          specialty participating as a delegate to the 2018 House of Delegates and all 17 trustee district delegations  
28          included specialist delegates.

29          The Board notes that representation in the House for students and the federal dentist services represent  
30          a very different situation as compared to specialists. Specialists are able to, and do, serve as  
31          delegates. But absent the provisions of the *Bylaws* that provide for five delegates from the American  
32          Student Dental Association and at least one delegate from each federal dental service, students and  
33          federal service dentists would have no representation in the House of Delegates. Students are not active  
34          members of the Association and are, therefore, ineligible to serve as delegates but for the Bylaws  
35          provision providing for the five ASDA delegates. Federal dentists are, by and large, direct members of  
36          the Association; because they are not members of constituent societies, federal service dentists are  
37          unable to be selected as delegates by the 53 constituent societies.

38          The Board Rules require ADA to meet with specialty group leadership at least once a year to maintain  
39          open lines of communication regarding issues of mutual concern. The Board welcomes ongoing input  
40          from dental specialists as regular delegates to the House of Delegates but recommends a No vote on this  
41          resolution.

**1 BOARD RECOMMENDATION: Vote No.****2 Vote: Resolution 77**

BLACK	No	GEHANI	No	KLEMMEDSON	No	RODRIGUEZ	Absent
COHLMIA	No	HARRINGTON	No	KYGER	No	SABATES	No
DOROSHOW	No	HERRE	No	LEARY	No	SHEPLEY	No
EDGAR	No	HIMMELBERGER	No	MCDUGALL	No	STEPHENS	No
FISCH	No	HUOT	No	NORBO	No	THOMPSON	No

**3**

Resolution No. 78 NewReport: N/A Date Submitted: July 2019Submitted By: Council on Advocacy for Access and PreventionReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None

Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_

Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

**1 RESPONSE TO RESOLUTION 55H-2018: ESTABLISHING A CULTURE OF SAFETY IN DENTISTRY**

**2 Background:** The dental profession has been diligent in its embrace of evidence-based dentistry (EBD)  
 3 and its benefits for patients, while creating a more efficient and equitable care system, and we are  
 4 headed in the right direction. As acknowledged in Resolution 55H-2018, an area of health care where  
 5 dentistry lags behind is safety, safety in our patient care and safety for ourselves and our dental team  
 6 (see current ADA policies referencing safety in the Appendix). Most dental professionals consider dental  
 7 care to be a safe and effective endeavor; but as our medical colleagues discovered two decades ago, we  
 8 do not know what we don't know. EBD is moving us toward knowing more about effectiveness, but the  
 9 dental profession lacks a mechanism and culture to address safety.

10 Over the past two decades, the U.S. health care system has invested in developing a robust monitoring  
 11 and reporting mechanism that has led to improvements in health care delivery and reduction in accidental  
 12 injury and medical errors. Almost every entity involved in health care (clinicians, hospital systems,  
 13 accrediting bodies, government agencies, and payers) acknowledges safety as a "fourth pillar" along with  
 14 health, value and cost. Outcomes in general health almost always include addressing unplanned injury or  
 15 harm. Introduction of new devices, drugs and materials requires evidence and deliberation. Hospital  
 16 systems and individual physicians track clinical outcomes and adverse events that directly affect patient  
 17 care, but also certifications, payment, and reputation. This collaboration produced less personal censure  
 18 of health care professionals, while redesigning systems to enhance individual safety and yield greater  
 19 transparency. This systems approach promoted a non-punitive, "win/win" scenario for all parties.

20 Organized general dentistry has begun to embrace the safety concept, particularly in reaction to events  
 21 like patient death, infection control lapses and material contamination. Most responses have been after-  
 22 the-fact, while realizing the value of root cause assessments and its metrics, slow adoption of continuous  
 23 quality improvement in dental practice, lack of awareness of types and numbers of safety events, and  
 24 unease about more regulation and cost for the dental practice. The extent of dentist error, its  
 25 consequences and an organized systematic approach to mitigate unintended injury (and in rare cases,  
 26 mortality) remain elusive in dental care delivery.

27 While embracing diversity, health disparities and patient advocacy, dental education has not emphasized  
 28 patient and dental team safety within its curricula or competencies.<sup>1</sup>

<sup>1</sup> The comments and examples largely come from the deliberations of an expert workgroup that was convened by phone and in person to address Res.55H-2018 and envision the roadmap that will arise from the proposed multi-year framework of action. Members include: David Perrott, dentist, The Joint Commission; Paul Casamassimo, AAPD pediatric dentist; Charles S. Czerepak, AAPD pediatric dentist; David White, Council on Government Affairs, general dentist; Leslie Grant, dentist, OSAP past board chair; Ana Karina Mascarenhas, Nova Southeastern Dental School, public health dentist; Rich Herman, CAAP chair; Lou Rafetto, AAOMS

Several dental specialties have begun to address safety. For example, in oral surgery, a registry of safety events has been started. Pediatric dentistry is developing a cloud-based safety resource for its membership and will convene a symposium on safety in pediatric dental practice this fall to begin educating its members. Dental radiologists foster gentle imaging of patients in pursuit of safer radiographic practice. Dentists working in public health settings routinely participate in program integrity measures, such as peer review and Quality Improvement efforts.

There is growing interest in promoting a systematic approach to fostering such a culture in dentistry, but there are few comprehensive reviews of dental adverse events, risks to provider safety, electronic systems protections or prevention of patient privacy breaches. Preliminary efforts point to the challenges of creating a "high-reliability" system that emphasizes information sharing through effective communication, so that practitioners can collectively learn from the experience of others without having to experience that adverse event themselves.

So where does the dental profession go from here? The first step is to admit there is an opportunity to improve the safety climate of dental practice --- not just in dental care, but in recognition that we just do not know. In response to Resolution 55H-2018, the Council on Advocacy for Access and Prevention has sought to define elements of safety in dentistry and offer recommendations for further action, which is a first step. These steps are necessary even if the dental profession deems dental care safe as dentistry will change over time. These latter steps will be years in development and implementation, but now is the time to begin this process in earnest.

Why now? Other parts of the health care system have added safety to their ongoing considerations in healthcare. Dentistry is two decades or more behind. The public and its advocates will ask why major safety events occur in dentistry when other aspects of human endeavor (like air travel) can have zero tolerance. There are thousands of new dental graduates each year who will undoubtedly face a far more stringent practice world with demands by payers and patients around safety; they will seek help from organized dentistry.

If this report is accepted and the following resolution approved, the assembled safety workgroup will continue to assess through conference calls and remote access platforms to review where progress is being made in developing this culture of safety in dentistry and seek alignment with the efforts of others internal and external to organized dentistry. In conjunction with these aligned stakeholders, a plan of action and success measures will be formulated in the first year of this project that will focus on the five strategic areas noted in the resolution. The Safety Workgroup will further refine a multi-year plan with annual reports to the House (See Appendix 2.)

Safety in health care is a profession's ultimate advocacy commitment. It means looking beyond what we do now. What more fitting validation of the ADA's recent commitment to patients in its mission statement than to embrace a culture of safety. If dentistry is to continue to be taken seriously as a health profession, it must demonstrate a visible commitment to better understand and promote safety in oral health care.

Therefore, the following resolution is presented for House consideration.

### Resolution

**78. Resolved**, that the appropriate ADA agency be tasked with implementing, in a measured and methodical manner, a three year framework for action that will begin to:

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representative; Muhammad Walji, University of Texas at Houston, dental safety consultant; Elsbeth Kalendarian, UCSF, dental safety consultant; Gregory Heintschel, MetroHealth System, chair of oral health and dentistry; Dan Klemmedson, oral surgeon and physician, ADA trustee <mailto:klemmedson@ada.org> (ex officio); and Steve Geiermann, CAAP staff dentist.

- Develop a curriculum on patient safety and encourage its adoption into training;
- Disseminate information on patient and dental team safety through a variety of in-person, print, web and social media communication vehicles on a regular basis;
- Recognize patient safety considerations in practice guidelines and in standards;
- Work collaboratively to develop community-based initiatives for error reporting and analysis; and
- Collaborate with other dental and healthcare professional associations and disciplines in a national summit on dentistry's role in patient safety.

and be it further,

**Resolved**, that an annual report be submitted to the ADA House of Delegates detailing progress in nurturing this culture of safety in order to raise awareness, while alleviating fear and anxiety associated with making the dental environment safe for patients, providers and the dental team.

**BOARD RECOMMENDATION: Vote Yes.**

**Vote: Resolution 78**

BLACK	Yes	GEHANI	Yes	KLEMMEDSON	Yes	RODRIGUEZ	Absent
COHLMIA	Yes	HARRINGTON	Yes	KYGER	Yes	SABATES	Yes
DOROSHOW	Yes	HERRE	Yes	LEARY	Yes	SHEPLEY	Yes
EDGAR	Yes	HIMMELBERGER	Yes	MCDUGALL	Yes	STEPHENS	Yes
FISCH	Yes	HUOT	Yes	NORBO	Yes	THOMPSON	Yes

**APPENDIX 1****Current ADA Safety Policies****Developing a Culture of Safety in Dentistry (Resolution 55H-2018)**

**Resolved**, that the American Dental Association commit to establishment of a "Culture of Safety" in all aspects of dental practice; and be it further

**Resolved**, that the appropriate ADA agency or agencies be tasked with a comprehensive review of patient and provider safety in dentistry; and be it further

**Resolved**, that a report be submitted to the 2019 ADA House of Delegates detailing the incidence and severity of patient and provider safety issues in dentistry, and recommendations for development of a plan to address the identified issues of concern.

**Patient Safety and Quality of Care (*Trans.2005:321*)**

**Resolved**, that it is the ADA's position that health care should be:

- *safe*—avoiding injuries to patients from the care that is intended to help them
- *effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)
- *patient-centered*—providing care that is respectful of and responsive to individual patient preferences, needs and values and ensuring that patient values guide all clinical decisions
- *timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care
- *efficient*—avoiding waste, including waste of equipment, supplies, ideas and energy
- *equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status

**Patient Safety (*Trans.2001:429; 2014:504*)**

**Resolved**, the Association work in cooperation with constituent and component dental societies and other major health care organizations to encourage the development of collaborative projects regarding patient safety, and be it further

**Resolved**, that appropriate Association agencies disseminate information on patient safety to the membership.

**Funding and Authority for Patient Protection (*Trans.1983:560*)**

**Resolved**, that constituent dental societies be encouraged to lobby legislatures to provide additional state dental board funding and authority for patient protection activities.

**State Responsibility for Health, Safety and Welfare (*Trans.1978:530*)**

**Resolved**, and reaffirmed, that the constitutional responsibility for the health, safety and welfare of the citizens of each respective state is the responsibility of each state and that state alone, and should not be abrogated, and be it further

**Resolved**, that the ADA does constantly reflect these feelings in their dealings with political leaders in all areas of government, and be it further

- 1 **Resolved**, that each dentist through his or her every area of influence do all in his or her power to
- 2 preserve this constitutional responsibility and right.
- 3

**APPENDIX 2****Developing a Culture of Safety in Dentistry  
Frequently Asked Questions****What is safety in dentistry?**

- Safety is the reduction of preventable harm to patients, caregivers, our staff and ourselves.
- We are protecting ourselves and our patients.

**What are examples of safety issues in dentistry?**

- Examples include: use of nitrous oxide, sedation issues, contaminated water lines, pain management, infection control, needle sticks, wrong site/wrong procedure, or medication errors.

**Doesn't dentistry already address safety?**

- Yes, but consider this mantra: "We are relatively safe, but could we do better!"
- The simplest concepts of "time outs" to verify the patient and procedure, as well as written checklists to make sure we are fully prepared, are good starts.
- We generally address individual events within our own practice. How can we learn collectively from others without fear of punitive retribution?
- Dentists in the U.S. average one emergency per year.

**If I talk about safety issues, won't I be putting myself at risk?**

- No, this is about finding a way to create systems to benefit all, so that everyone can learn from others without having to experience the adverse event themselves (whatever that might be).

**What do you mean creating a system to promote safety?**

- Consider the safety of flying. One does not have to crash a plane to learn how not to crash one! The Federal Aviation Administration tracks adverse events in aviation, citing suspected causes and making recommendations on how to avoid those situations in the future, which are available to all pilots. Flying is considered one of the safest activities due to this adherence to a "zero harm" goal.
- Dental safety programs should focus on system improvements rather than punitive measures. Don't create a culture of blame, rather create an environment of transparency, where all can learn and improve. Adverse event reporting can be anonymous, not mandated.
- The safest systems do not rely upon the practitioner to avoid making errors; they rely upon a series of safety barriers that prevent the harm from occurring.

**Doesn't dentistry have such a reporting system for adverse events?**

- Not at this time! Oral surgeons have begun to create a national registry where they might voluntarily contribute information, so that others can learn from and avoid similar events.

**What is the cost of implementing a safety program?**

- Minimal, when you see it as a return on investment mitigating or avoiding preventable harm to yourself, your staff or your patient.
- When we fail to govern ourselves, others could step in and do it for us.
- We have the ability to be proactive and limit reactivity to an environment that is focused on increasing accountability for safety, transparency and improvement.

**What are the essential elements of such a safety initiative?**

- Identify threats to patient/staff safety
- Identify and evaluate effective safety practices
- Educate, disseminate info, implement best practices and raise awareness
- Monitor threats to patient/staff safety to ensure that a safe environment continues

**1 What needs to be done to move safety forward?**

- 2 • Organizations can work to improve and promote the culture of safety
- 3 • Academia can help educate future and current oral health professionals about safety
- 4 • Practitioners can implement and evaluate steps taken towards improving safety.

**5 Safety is an ethical issue. How so?**

- 6 • All professions have a code of conduct. Ours includes beneficence (doing good), patient  
7 autonomy, veracity (truthfulness), justice and non-maleficence (do no harm). These are  
8 commonly stated as an expectation of:
  - 9 ○ **Selflessness**: placing the needs and concerns of our patients above our own
  - 10 ○ **Skill/competence**: excellence in our knowledge and expertise
  - 11 ○ **Trustworthiness**: we will be responsible in our personal behavior towards others
  - 12 ○ **Discipline**: following prudent procedures in functioning with others
- 13 • Discipline is hard. We have to work at it.

**14 Are we talking about deaths in the dental office? What does the data show?**

- 15 • There is little comprehensive data on adverse events in the dental office, and “death” is only a  
16 small aspect of safety. To the best of our knowledge, 218 people died in the dental chair  
17 between 1955 and 2017 as far as we can determine considering that there is no mandatory  
18 reporting of such incidents.
- 19 • This was drawn from 20 studies that reported death due to a dental procedure over this period of  
20 time.

**21 Safety is more than avoiding death in the dental chair?**

- 22 • We are not solely focusing on death in dentistry, especially sedation-related death, as safety is  
23 much bigger than that extreme situation.

**24 What about sedation deaths?**

- 25 • The challenges that dentistry had had in anesthesia are coming home to roost. The American  
26 Society of Anesthesia is opposing the single operator-anesthetist model for children. Dentistry  
27 runs the risk of losing the ability to provide certain levels of anesthesia in the office setting. By  
28 addressing safety earlier, this might have been avoided.
- 29 • One death is too many. Adverse events in dentistry are rarely brought to light unless the media  
30 gets wind of them. It was originally sedation deaths in Texas that brought safety to the attention  
31 of the Council.
- 32 • Several dental specialties are actively seeking to address safety, including: pediatric dentists, oral  
33 surgeons, radiologist, dental anesthesiologists and those who work in public health settings.
- 34 • Safety may not be recognized as a problem, but it is constantly utilized as an argument against  
35 consumerism, workforce recommendations and practice models. By “walking the walk we talk,” it  
36 will be much more legitimate for us to hold others to our “culture of safety.” This could create a  
37 valuable weapon in our arsenal for advocating on a number of issues.

**38 Why would this be a multi-year effort?**

- 39 • Single year efforts often conclude with a set of recommendations that are never fully realized. A  
40 multi-year effort allows for graduated implementation, which lowers total cost and allows for  
41 higher priority items to be emphasized first.
- 42 • Our medical colleagues continue to gradually add to and improve their “culture of safety.” In all  
43 likelihood, our effort will be an ongoing one as well, with all dentists involved.

Resolution No. 80 New

Report: N/A Date Submitted: August 2019

Submitted By: Fourteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1

**ADA POLICY ON VAPING**

2 The following resolution was adopted by the Fourteenth Trustee District and submitted on August 9,  
3 2019, by Dr. David White, caucus chair, Fourteenth District.

4 **Background:** The ADA currently has no policy on the use of e-cigarettes and vaping. The FDA currently  
5 regulates the manufacturing and sale of E-cigarettes. There is a current public perception that the use of  
6 these products may be a beneficial alternative to smoking tobacco. The American Dental Association  
7 should develop policies to inform its members and the public of the risks and detrimental effects of the  
8 use of these products.

9

**Resolution**

10 **80. Resolved,** that the ADA encourage research on vaping and develop a method for dentists to  
11 report injuries that result from patient vaping, and be it further

12 **Resolved,** that the ADA develop evidence-based policy on the effect of vaping on oral health, and be  
13 it further,

14 **Resolved,** that progress be reported to the ADA 2020 House of Delegates.

15 **BOARD COMMENT:** The Board applauds District 14 for calling attention to the oral health risks  
16 associated with electronic nicotine delivery systems (ENDS), sometimes called “e-cigarettes,” “vapes,” “e-  
17 hookahs” and “vape pens.” The Board shares the concern about the effect of these products may have  
18 on oral health.

19 The policy titled Policies and Recommendations on Tobacco Use (*Trans.*2016:323) already calls on the  
20 Association to lobby for additional research on the effects of these products on oral health. Additionally,  
21 the Food and Drug Administration (FDA) already has a mechanism in place to enable dentists to report  
22 injuries that result from vaping. The ADA has also embarked on the creation of a data warehouse for  
23 dentistry.

24 The Board believes that the Council on Advocacy for Access and Prevention is currently considering  
25 updating this policy, and that this new policy would not add to the Association’s ongoing efforts and  
26 therefore recommends that Resolution 80 not be adopted.

1 **BOARD RECOMMENDATION: Vote No.**2 **Vote: Resolution 80**

BLACK	No	GEHANI	No	KLEMMEDSON	Yes	RODRIGUEZ	Absent
COHLMIA	No	HARRINGTON	No	KYGER	No	SABATES	No
DOROSHOW	No	HERRE	No	LEARY	No	SHEPLEY	No
EDGAR	Yes	HIMMELBERGER	No	MCDUGALL	No	STEPHENS	No
FISCH	No	HUOT	No	NORBO	No	THOMPSON	No

3 **Links to Research Materials and Articles**

4 [https://www.ada.org/en/~media/ADA\\_Foundation/Files/ADA-Foundation-VRC-Vaping-Research-](https://www.ada.org/en/~media/ADA_Foundation/Files/ADA-Foundation-VRC-Vaping-Research-and-Health)  
5 [and-Health](https://www.ada.org/en/~media/ADA_Foundation/Files/ADA-Foundation-VRC-Vaping-Research-and-Health)

6 [https://www.cdc.gov/tobacco/data\\_statistics/sgr/e-cigarettes/index.htm#report](https://www.cdc.gov/tobacco/data_statistics/sgr/e-cigarettes/index.htm#report)

7 [https://jada.ada.org/article/S0002-8177\(15\)00713-8/abstract](https://jada.ada.org/article/S0002-8177(15)00713-8/abstract)

8 <https://ebusiness.ada.org/education/viewcourse.aspx?id=342>

9 [https://e-cigarettes.surgeongeneral.gov/documents/surgeon-generals-advisory-on-e-cigarette-](https://e-cigarettes.surgeongeneral.gov/documents/surgeon-generals-advisory-on-e-cigarette-use-among-youth-2018.pdf)  
10 [use-among-youth-2018.pdf](https://e-cigarettes.surgeongeneral.gov/documents/surgeon-generals-advisory-on-e-cigarette-use-among-youth-2018.pdf)

11 [https://www.cdc.gov/tobacco/data\\_statistics/sgr/e-cigarettes/pdfs/2016\\_sgr\\_entire\\_report\\_508.pdf](https://www.cdc.gov/tobacco/data_statistics/sgr/e-cigarettes/pdfs/2016_sgr_entire_report_508.pdf)

Resolution No. 81 New

Report: N/A Date Submitted: August 2019

Submitted By: Fourteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: \$8,000 Net Dues Impact: \$.77

Amount One-time \$8,000 Amount On-going

ADA Strategic Plan Objective: None

How does this resolution increase member value: See Background

# 1 STUDY INNOVATIONS FOR ALTERNATE STUDENT LOAN REPAYMENT STRATEGIES

2 The following resolution was adopted by the Fourteenth Trustee District and submitted on August 9,  
3 2019, by Dr. David White, caucus chair, Fourteenth District.

4 **Background:** The current federal government student loan forgiveness programs are antiquated. The  
5 current programs in effect will fail to attract future dental graduates, as these programs and compensation  
6 levels were formulated decades ago and would have been attractive to graduates in the past with  
7 reasonable student loan debt. The dental graduate of today has unprecedented debt and may be  
8 employed at several locations.

9 Currently, applicants who receive grants from the Indian Health Services (IHS) can be awarded \$20,000  
10 per year for a full-time two-year commitment; the National Health Service Corps will forgive up to \$50,000.  
11 Public service loan forgiveness can be awarded to full time dentists by the Health Resources & Services  
12 Administration (HRSA); additionally, most states also provide for some form of student loan forgiveness  
13 programs and they too are based on a full-time commitment for the majority of programs. As many dental  
14 school graduates with debts in excess of \$300,000 are piecing together a full-time schedule with multiple  
15 models of practice, it would seem reasonable that dentists could be awarded these same financial awards  
16 as a *part time* contributor to work in poor access-to-care areas.

## 17 Resolution

18 **81. Resolved,** that the ADA appoint a committee to study and address innovations in alternate  
19 student loan repayment strategies to accommodate current models of dental practice, including part-  
20 time practitioners and dental school faculty, and be it further

21 **Resolved,** that the committee report to the ADA 2020 House of Delegates.

22 **BOARD COMMENT:** The Board recognizes that dental student debt is a very serious issue. However,  
23 the Board notes that since 2010 there have been thirteen resolutions calling for actions on student debt,  
24 including the formation of several task forces. The work of these task forces has resulted in new  
25 programs, debt management tools, accreditation standards and ongoing advocacy and research. The  
26 Board estimates that between 2010 and 2017, the ADA spent approximately \$500,000 studying,  
27 addressing and advocating for change on this matter. In addition, this year the ADA and ASDA Boards  
28 met jointly to discuss student debt and the ADA Board had strategic discussions on the issue. Both  
29 Boards will continue to work in collaboration.

Moreover, the policy titled Advocacy for Student Loan Forgiveness and Other Educational Debt Reduction Programs (*Trans.*2014:502) already calls on the ADA to support pioneering ways to reduce the burden of dental student debt, including loan repayment incentives to practice in underserved areas. Recently, the ADA has been leading a coalition to reform the Public Service Loan Forgiveness program, which has been under scrutiny for being so poorly managed.

The Board believes another task force would not add to the Association's ongoing efforts and therefore recommends that Resolution 81 not be adopted.

**BOARD RECOMMENDATION: Vote No.**

**Vote: Resolution 81**

BLACK	No	GEHANI	No	KLEMMEDSON	Yes	RODRIGUEZ	Absent
COHLMIA	No	HARRINGTON	No	KYGER	No	SABATES	No
DOROSHOW	No	HERRE	No	LEARY	No	SHEPLEY	No
EDGAR	No	HIMMELBERGER	No	MCDUGALL	No	STEPHENS	No
FISCH	No	HUOT	No	NORBO	No	THOMPSON	No

Links to Research Materials and Articles: <https://nhsc.hrsa.gov/sites/default/files/NHSC/loan-repayment/nhsc-lrp-fact-sheet.pdf>  
<https://www.ihs.gov/dentistry/>

Resolution No. 82 New

Report: N/A Date Submitted: August 2019

Submitted By: Fourteenth Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

# 1 **ATTRACTING NEW DENTAL EDUCATORS**

2 The following resolution was adopted by the Fourteenth Trustee District and submitted on August 9,  
3 2019, by Dr. David White, caucus chair, Fourteenth District.

4 **Background:** Nationally, dental schools are faced with a shortage of dental clinic instructors. The  
5 federal government does offer grants to attract professional instructors. The current federal rules make it  
6 challenging for the institution or the dentist to take advantage of some federal monies. Revising these  
7 requirements to attract new educators including retirees from our profession to take academic positions  
8 can be better utilized by offering better incentives and fewer restrictions. This may include retirement  
9 benefits for those more seasoned dentists, and student loan forgiveness for part timers, as most  
10 individuals who have recently graduated will be repaying loans for decades.

11 The benefits to encouraging new legislation or changes in current federal policy would be three-fold: (1)  
12 Federal facilities and states would have a viable way to fill the void in educational facilities most of which  
13 service poor access to care populations, thus enabling more highly trained dentists to serve patients; (2)  
14 Graduates would be able to reduce their debt load upon graduation with loan forgiveness by serving as a  
15 part time dentist while also having the opportunity to pursue other modes of practice<sup>1</sup>; (3) Dental schools  
16 could attract more diverse faculty perhaps retired dentists through non-taxable retirement credits, as there  
17 is a nationwide shortage of dentists and specialists interested in academia.

## 18 **Resolution**

19 **82. Resolved,** that the ADA explore innovative models to attract recently graduated or retired  
20 dentists into academic settings, and be it further

21 **Resolved,** that the ADA should support federal legislation that is meant to attract dentists to  
22 academic settings.

23 **BOARD COMMENT:** The Board applauds District 14 for calling attention to dental school faculty  
24 shortages across the United States. The Board also is alarmed by the shortage of dental school  
25 instructors.

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<sup>1</sup> HRSA Dental Faculty Loan Repayment Program:  
<https://bhw.hrsa.gov/fundingopportunities/?id=546d7731-0f5a-4e5c-af8c-f90cc73800e3>

1 The policy titled Advocacy for Student Loan Forgiveness and Other Educational Debt Reduction  
 2 Programs (*Trans.*2014:502) already calls on the ADA to support pioneering incentives to encourage  
 3 dentists to enter and remain in academic teaching and research positions. In fact, the ADA is currently  
 4 leading a coalition to lobby for legislation to enhance the Dental Faculty Loan Repayment Program, which  
 5 was created to use student loan forgiveness as an incentive to recruit dental school faculty.

6 The Board believes a new policy would not add to the Association's ongoing efforts and therefore  
 7 recommends that Resolution 82 not be adopted.

8 **BOARD RECOMMENDATION: Vote No.**

9 **Vote: Resolution 82**

BLACK	No	GEHANI	No	KLEMMEDSON	Yes	RODRIGUEZ	Absent
COHLMIA	No	HARRINGTON	No	KYGER	No	SABATES	No
DOROSHOW	No	HERRE	No	LEARY	No	SHEPLEY	No
EDGAR	No	HIMMELBERGER	No	MCDUGALL	No	STEPHENS	No
FISCH	No	HUOT	No	NORBO	No	THOMPSON	No

Resolution No. 83 New

Report: N/A Date Submitted: August 2019

Submitted By: First Trustee District

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: \$33,000 Net Dues Impact: \$0.32

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

1 **AVAILABILITY OF ADA PUBLICATION FLUORIDATION FACTS**

2 The following resolution was submitted by the First Trustee District and transmitted on August 9, 2019, by  
3 Dr. Richard J. Rosato, caucus chair.

4 **Background:** The American Dental Association positions itself as the leader in Oral Health, and  
5 community water fluoridation is a key element in the prevention of oral disease. Further, knowledge of  
6 community water fluoridation can be invaluable in educating the public in the advancement of oral health.  
7 For these reasons, we propose making Fluoridation Facts available at no cost to the public.

8 **Resolution**

9 **83. Resolved,** that the American Dental Association Publication, Fluoridation Facts, be made  
10 available, in its digital format, at no cost to the public.

11 **BOARD COMMENT:** The Board applauds the efforts of the First District to educate the public on the  
12 value of community water Fluoridation but has concerns regarding the result of an electronic version of  
13 Fluoridation Facts available to the public at no cost.

14 The content of the book is highly scientific in nature and presents discussion of complicated subject  
15 matter which could be confusing to the general public.

16 The Board recommends instead that the Fluoridation website of MouthHealth.org have an increase of  
17 consumer friendly materials developed by the National Fluoridation Advisory Committee within the  
18 Council on Advocacy for Access and Prevention, including one page documents which members could  
19 utilize in their community education efforts.

1

2 **BOARD RECOMMENDATION: Vote No.**3 **Vote: Resolution 83**

BLACK	No	GEHANI	No	KLEMMEDSON	No	RODRIGUEZ	Absent
COHLMIA	No	HARRINGTON	No	KYGER	No	SABATES	No
DOROSHOW	No	HERRE	No	LEARY	No	SHEPLEY	No
EDGAR	No	HIMMELBERGER	No	MCDUGALL	No	STEPHENS	No
FISCH	Yes	HUOT	No	NORBO	No	THOMPSON	No

4

Resolution No. 84 New

Report: N/A Date Submitted: August 2019

Submitted By: Virginia Dental Association

Reference Committee: D (Legislative, Health, Governance and Related Matters)

Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

# CLARIFICATION OF ADA POLICY REGARDING TOBACCO PRODUCTS

The following resolution was submitted by the Virginia Dental Association and transmitted on August 11, 2019, by Dr. Kirk Norbo, Sixteenth District Trustee.

**Background:** There is some concern that the current ADA policy on tobacco may be limiting. As times change and options change, so must ADA policy to keep "up to date." The current statement should be longer and more detailed describing the situation.

## Resolution

**84. Resolved,** that the ADA research and consider adding the word "vaping" and any other commonly used term or method of nicotine delivery systems and add such language to the ADA policy on tobacco and any other policy statements related to smoking, nicotine delivery, etc., and be it further

**Resolved,** that this be referred to the appropriate Council, committee, or agency and that a report be made to the 2020 ADA House of Delegates with suggested language for debate and discussion on updating current ADA policy.

**BOARD RECOMMENDATION: Vote Yes.**

**Vote: Resolution 84**

BLACK	Yes	GEHANI	Yes	KLEMMEDSON	Yes	RODRIGUEZ	Absent
COHLMIA	No	HARRINGTON	No	KYGER	Yes	SABATES	No
DOROSHOW	Yes	HERRE	No	LEARY	Yes	SHEPLEY	No
EDGAR	Yes	HIMMELBERGER	No	MCDUGALL	Yes	STEPHENS	No
FISCH	Yes	HUOT	Yes	NORBO	Yes	THOMPSON	No

Resolution No. None N/AReport: Board Report 10 Date Submitted: August 2019Submitted By: Board of TrusteesReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

## REPORT 10 OF THE BOARD OF TRUSTEES TO THE HOUSE OF DELEGATES: REFOCUSING THE WORK OF THE ADA FOUNDATION

**Background:** The ADA Board of Trustees, acting as the sole member of the ADA Foundation, has made the decision to refocus the work of the Foundation. This is the culmination of several years of in-depth analysis of both philanthropic and research activities by the ADA Board of Trustees and the ADA Foundation Board. The ADA Board concluded that the Foundation as structured was not financially sustainable. Negative economic trends in grants, royalties and fundraising exposed financial and operational liabilities that needed to be addressed. The Foundation will be renamed over the next several months but for simplicity is referred to as the "Foundation" in this report.

To promote the important ADA role in science and research and to protect some key philanthropic activities such as *Give Kids a Smile*, decisive action was needed. The Board acted by shifting the focus of the Foundation towards science and research and away from philanthropic activities and fundraising. This decision was informed by the ADA Bylaws, Ch. III, par. 50G: "[It shall be the duty of the House of Delegates to...] Provide sufficient support to the ADA Foundation in addition to non-Association funding to assure the continued viability of the Foundation research activities."

The Board decided to combine the ADA Science Institute with the ADA Foundation science operation. For many years, science activities were split between ADA and the Foundation. The Science Institute houses the ADA science projects, standards development and oversees the ADA Seal Program. The Foundation has funded scientific research at the Volpe Research Center located on the National Institute for Standards and Technology campus. Efficient administration and scientific operations were hindered by this divided organizational structure.

Research functions of the Science Institute and the Volpe Research Center will be combined within the Foundation to leverage the strengths of each. A renewed focus on the creation and translation of scientific knowledge and the development of new products and technology to advance the health of the public supports achievement of the ADA's new strategic plan, *Common Ground 2025*. The Foundation will become a more competitive, national leader in the scientific community, attract more research grants, and drive more innovative research outcomes. The Council on Scientific Affairs will remain within the ADA and will coordinate closely with some of the work of the refocused Foundation.

The Board directed the new Foundation board to narrow the focus of philanthropy in the Foundation as quickly as practical while complying with all laws and donor intent. Key philanthropic activities of the Foundation were identified as vital and will continue. *Give Kids a Smile* is the primary example. That program will continue through cooperative agreements between the ADA and the Foundation and will be

funded in part through existing Foundation funds. Other funds within the Foundation that do not meet the narrowed philanthropic focus will be spent down on programs within the donor's fund designation and closed. Several endowed funds will continue to exist for the foreseeable future and be administered within the ADA through a services agreement. The outcome will be a more sharply focused Foundation.

This transition is incredibly complex. The Board has been guided by the ADA's Legal Division as well as outside legal expertise. The transition will continue through next year. The BOT's desired outcome is a stronger Foundation focused on science and continued support for key philanthropic activities in cooperation with the ADA. A small Foundation board has been constituted to manage the transition. The board members will be the ADA President, President-Elect, one Trustee, and the Executive Director. A skills-based board with expertise in science and research will be constituted as soon as transition progress allows. We thank all past Foundation board members and especially the immediate past president, Dr. William Calnon, for their hard work and dedication.

The ADA Board of Trustees understands the critical need for an evidence-based healthcare profession to have an active role in science and is committed to support that effort. The Board also recognizes the need for our Association to contribute to the public good through philanthropic efforts. Philanthropic programs support our new Strategic Plan, and provide valuable narrative for advocacy efforts our other divisions engage in. The transition of the Foundation will allow both of these duties to be fulfilled; science and research to be primarily housed within the Foundation and philanthropy to be jointly conducted through Foundation funding and ADA administration.

### Resolutions

This report is informational and no resolutions are presented.

### BOARD RECOMMENDATION: Vote Yes to Transmit.

#### Vote: Board Report 10

BLACK	Yes	GEHANI	Yes	KLEMMEDSON	Yes	RODRIGUEZ	Absent
COHLMIA	Yes	HARRINGTON	Yes	KYGER	Yes	SABATES	Yes
DOROSHOW	Yes	HERRE	Yes	LEARY	Yes	SHEPLEY	Yes
EDGAR	Yes	HIMMELBERGER	Yes	MCDUGALL	Yes	STEPHENS	Yes
FISCH	Yes	HUOT	Yes	NORBO	Yes	THOMPSON	Yes

Resolution No. None N/AReport: Council on Government Affairs Report 1 Date Submitted: July 2019Submitted By: Council on Government AffairsReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: Not Applicable

**COUNCIL ON GOVERNMENT AFFAIRS REPORT 1 TO THE HOUSE OF DELEGATES: ADA POLICY REVIEW**

**Background:** In accordance with Resolution 170H-2012 (*Trans.*2010:603; 2012:370), Regular Comprehensive Policy Review, the Council on Government Affairs reviewed the following Association policies and determined that they should be maintained.

Dentistry in the Armed Forces (*Trans.*1972:718; 2012:496)  
 Government Intrusion into Private Practice (*Trans.*1976:857)  
 Tax Deductibility of Dental and Medical Expenses (*Trans.*1982:549; 1989:548)  
 Campaign Finance Reform (*Trans.*1987:520)  
 Employer Subsidy (*Trans.*1993:665)  
 Freedom of Choice in Selection of Health Care Provider Under Health Care System Reform (*Trans.*1993:717)  
 Tax Preferred Accounts (*Trans.*1994:637; 2012:495)  
 Employer Mandates (*Trans.*1994:645)  
 Office of the U.S. Surgeon General (*Trans.*1995:318; 2012:372)  
 States' Rights Affecting the Practice of Dentistry (*Trans.*1995:649; 1996:715)  
 Affiliation With the Alliance of the American Dental Association (*Trans.*1997:701)  
 Universal Healthcare Reform (*Trans.*2008:433)

The Council has submitted resolutions to amend or rescind other ADA policies based on their continued need, relevance and consistency with other Association policies. Those recommendations are contained on separate worksheets.

**Resolution**

This report is informational and no resolutions presented

**BOARD RECOMMENDATION: Vote Yes to Transmit.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. None N/AReport: Council on Communications Report 1 Date Submitted: July 2019Submitted By: Council on CommunicationsReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: The ADA will support the advancement of the health of the public and the success of the profession.

How does this resolution increase member value: See Background

## **COUNCIL ON COMMUNICATIONS REPORT 1 TO THE HOUSE OF DELEGATES: REQUEST TO PROVIDE ADDITIONAL FUNDING FOR UTILIZATION CAMPAIGN**

**Purpose of Report:** The Council on Communications believes that the Utilization/Find-a-Dentist campaign has proven to be a positive member benefit. Although the proposed budget in Board Report 2 provides \$340,000 for paid search to support the program, the Council believes this is insufficient, and that more funding is needed for paid search to keep the tool viable. Therefore, the Council on Communications will testify at the appropriate reference committees and is prepared to make a motion on the floor the House of Delegates to recommend the return of the proposed budget to the Board of Trustees with instructions to add an additional \$1million to fund the Utilization/Find-a-Dentist campaign.

**Background:** In 2015, House Resolution 90 (*Trans.2015:285*) was referred to the appropriate ADA agency for further study and report to the 2019 House of Delegates. The following year, the Council on Communications proposed and the House adopted Resolution 67H (*Trans.2016:278*), a Three-Year Campaign to Increase Utilization of Dental Services for ADA Members. In other words, to encourage adult patients to see an ADA Dentist. The campaign included transforming the ADA Find-a-Dentist tool, populating the new tool with member information and photos, and supporting the tool with paid search and digital advertising. The total budget for the three-year campaign was \$18.3 million; \$6.3 million in the first year and \$6 million per year for years two and three. The three-year pilot will conclude at the end of 2019.

The 2020 Marketing and Communications budget currently has \$340,000 earmarked for paid search to support the Find-a-Dentist tool. The Council on Communications believes that the campaign merits expanded funding because it constitutes a member benefit that offers marketing support for members at no extra cost beyond dues dollars. After reviewing the Utilization Campaign results and considering options for the future of the campaign, the Council recommends that the campaign be funded at an additional \$1 million to support paid search to sustain the campaign.

### **Campaign Metrics**

The campaign met or exceeded all benchmarks outlined at the beginning of the campaign. Since the campaign launched in April 2017, and as of June 2019, the campaign generated:

- 6.6 million visits to the Find-a-Dentist tool.
- 1.6 million completed searches.

- 2.8 million profile views. The reason the profile view number is higher than completed searches is that many site visitors view more than one profile.
- Throughout the campaign, between 15 and 18% of profile views resulted in an action to contact a member dentist, including clicks to the member's website, email or click to call the practice phone. This far surpasses the industry standard of 1-2%.

A separate report on the campaign will be delivered to the House in the Council on Communications Annual Report. Note that the campaign was never designed to measure appointments scheduled, but rather give members the opportunity to connect with patients.

### Campaign Benefits

Due to the substantial investment in search ads, the ADA has realized a three-fold benefit:

- Optimized paid search traffic to maximize traffic to ADA member profiles at the lowest cost.
- Improved Google ranking of all ADA.org content due to the popularity of Find-a-Dentist.
- Consistent increases in organic/unpaid traffic to Find-a-Dentist over the course of the 3-year program.
- In addition, many members have enjoyed the unintended benefit of increased traffic to their office websites through Find-a-Dentist click-throughs, and improved visibility in Google search via their personal ADA profile page.
- Members receive a boost in traffic by being associated with ADA's high-performing website.
- The initiative included an outbound calling campaign, resulting in updated member data from more than 83,031 members. Cleaner data provides enterprise-wide benefits at a national, state and local level, and also helps the ADA communicate more effectively with members. Currently 69.3% of eligible members are updated in the Aptify database.

### Rationale for Additional Funding

An ongoing investment in search ads is required to secure strong organic/unpaid traffic to Find-a-Dentist. Without continuous investment in search ads the overall unpaid/organic search rankings will drop, ultimately diminishing the program's success as traffic and profile views decline.

The rationale for \$1.34 million versus the \$6 million in the pilot is directly related to insights gained throughout the early years of the campaign:

- Search for dentists is seasonal. The campaign can deliver a benefit without being live every day.
- By utilizing high-performing words (identified during the pilot), we've maximized our budget dollars by focusing only on keywords that deliver visits to Find-a-Dentist, also known as conversions.
- Maintaining paid search also boosts unpaid/organic search.

The Council on Communications believes the pilot campaign has delivered valuable learnings and efficiencies through a series of tests over the last few years. Therefore it recommends the program continue at the \$1.34 million amount focused exclusively on paid search during seasons when adult patients are more likely to search for a dentist.

### Resolution

This report is informational and no resolutions presented

**BOARD RECOMMENDATION: Vote Yes to Transmit.**

- 1 **BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO**
- 2 **BOARD DISCUSSION)**

Resolution No. None N/AReport: Fight Insurer Interference Strategic Taskforce (FIIST) Date Submitted: July 2019Submitted By: FIIST TaskforceReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Membership-Obj. 1: Leaders and Advocates in Oral Health

How does this resolution increase member value: See Background

**REPORT OF THE FIGHT INSURER INTERFERENCE STRATEGIC TASKFORCE TO THE HOUSE OF DELEGATES: RESPONSE TO RESOLUTION 32H-2018**

**Background:** In 2018, the House of Delegates adopted Resolution 32H, noted below, leading to the creation of the “Fight Insurer Interference Strategic Taskforce” (FIIST).

**32H-2018. Resolved,** that a task force be convened to develop a broad-reaching strategy for state-based dental benefits advocacy to minimize interference of dental benefit carriers into the doctor-patient relationship. This strategy should include the development of policy actions that states can include in their respective advocacy agendas and what public affairs support would be needed to ensure successful outcomes and, be it further

**Resolved,** that the task force be comprised of equal representation from the Board of Trustees, Council on Dental Benefits, Council on Government Affairs, at-large Delegates or Alternate Delegates of the 2018 House of Delegates, and state dental association executive directors with dental benefits advocacy experience and, be it further

**Resolved,** that the task force shall report its strategy recommendations to the 2019 ADA House of Delegates

The Taskforce’s goal was to develop a strategy for state-based dental benefits advocacy to minimize interference of dental benefit carriers into the doctor-patient relationship. In developing the strategy the Taskforce assessed:

- long and short term trends in the dental benefits industry that impinge on the private practitioner opportunities at both the state and the federal levels
- relevant public affairs strategies deployed by states and their outcomes (analysis of successes, failures, and challenges)
- relevant state level policy actions related to third party issues (analysis of successes, failures, and challenges)

In forming the Taskforce, ADA President Dr. Jeffrey Cole appointed the following members to FIIST:

Dr. Roy Thompson, ADA board member and chair; Dr. Paul Calitri, council on dental benefits; Dr. Ariane Terlet, council on government affairs; Dr. Duc Ho, House of Delegates, Mr. David Owsiany, state executive director. Serving as consultants to FIIST from state dental associations: Ms. Carol Dingeldej, Connecticut State Dental Association; Mr. Bracken Killpack, Washington State Dental Association; Ms. Laura Givens, Virginia Dental Association; Dr. Alec Parker and Ms. Lisa Ward, North Carolina Dental

Society; Mr. Mark Paget, Wisconsin Dental Association; Mr. James Schulz, New Jersey State Dental Association and Ms. Lynn Means, Oklahoma Dental Association.

### Dental Benefits Landscape

The dental benefits landscape has shifted in the last decade and, though incremental, the changes are significant.

Preferred provider organizations (PPO's) have grown from 67% in 2008 to 85% in 2017.<sup>1</sup> The rise in PPO's has occurred at the cost of indemnity plans (e.g. Delta Premier) and traditional discount plans. Average in-network discounts for PPO's are significantly higher than for dental indemnity plans affecting revenue for dental offices.

There is also a trend toward lower reimbursement for in-network dental services. "The fees for the three most common endodontic and oral surgery procedures have increased from 2005 to 2014; however, the increase in reimbursement rates from third-party payers is not at par with the increase in fees. The fees for the three most often performed prosthodontic and periodontal procedures have increased from 2005 to 2014; however, the reimbursement rates have decreased over the same timeframe."<sup>2</sup> Carriers lower the reimbursements to dentists while the costs dentists incur to provide those services trend upward.

Another significant trend is that more dentists are part of an increasing number of networks. On average dentists are participating with at least 13 carrier networks each.<sup>3</sup> This may be due to dentists seeking to make up in patient volume what they are losing on the discount to their fees they accept. The problem is further exacerbated by payers "swapping", "stacking" and "leasing" networks without notifying dentists. To add to this burden of increasing discounts, carriers may also attempt to impose "most-favored nation" clauses in their contracts with dentists, mandating that their subscribers receive the lowest discount the dentist has agreed to. Dentists are caught in a race to the bottom and frustration is growing.

A significant portion of the dental benefits industry has shifted to administrative services only (ASO)/self-funded arrangements where the dental carrier is functioning as a third party administrator for the benefit purchaser.<sup>4</sup> Although ASO plans are governed by Employee Retirement Income Security Act (ERISA), a federal law, a steady trend of dental benefit state law enactments may force carriers to comply across their systems. For example, in the case of non-covered services, carriers reported that they comply with their domiciled state's law because of the inefficiency in administering claims two different ways based on whether the patient is covered by a self-funded or fully-insured plan.

### Dental Benefits FIIST Survey

The American Dental Association's department of State Government Affairs performed an exhaustive review of the dental benefit public policy environment. As a result of the review, over 30 possible legislative/regulatory concepts were catalogued that can be considered for adoption as state law (i.e. Assignment of Benefits, Non-Covered Services or Network Leasing regulations). In order to prioritize, the department asked FIIST members and consultants to rank the concepts from 1-10 with 10 having the greatest impact on dentistry.

<sup>1</sup> 2018 State of the Dental Benefits Market 2019, National Association of Dental Plans, Inc.

<sup>2</sup> Gupta N, Vujicic M, Blatz A. Trends in fees and reimbursement rates for most common procedures in endodontics, periodontics, prosthodontics, and oral surgery. Health Policy Institute Research Brief. American Dental Association. April 2017 (Revised). Available from: [http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief\\_0217\\_2.pdf](http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0217_2.pdf)

<sup>3</sup> NADP Dental Benefits Report: Network Administration and Network Statistics May 28, 2019

<sup>4</sup> In 2008, ASO market was 42% of the commercial market compared to 48% in 2017. 2018 State of the Dental Benefits Market 2019, National Association of Dental Plans, Inc.

Among the highest ranking concepts were:

- Assignment of Benefits (22 States identified as having such a law)
  - Laws empower patients to have their benefit payment sent directly to dentist. Relieves patient of paying up-front charges; helps dentist with greater predictability on payment.
- Disallow Clause (0 States identified as having such a law)
  - This law would prohibit any contract provision that prevents a dentist from charging a covered person for a covered procedure not paid for/disallowed by the benefit plan. The law would prohibit contract provisions saying no payment will be made for a covered service by the dental plan AND the participating dentist may not collect payment from the covered person for the covered service disallowed by the dental plan.
- Most Favored Nation (7 States identified as having such a law)
  - If not prohibited by law, plans can reduce their claim payment to meet the lowest fee paid by any other plan in which the dentist participates. Laws can be pursued to prohibit such reductions.
- Retroactive Denials (20 States identified as having such a law)
  - Dental plans have the ability to review claims after payment has been delivered and request claims payment refunds under certain circumstances. The profession is interested in laws that restrict the timeframe allowed to request such a refund. Laws in this category restrict refund requests to one or two years after payment.
- Network Leasing (15 States identified as having such a law)
  - Transparency - Requires benefit plans to notify when they share their network of providers with another third party. Allows dentist to control which dental plans they choose to join. Could include rights for dentists to opt-out, no changes to original contract or complete prohibition.

These concepts were identified as public policy tools (legislative proposals) that would have the greatest impact on dental practices' daily operations.

## Pilot Projects

SPA funded six pilot projects in 2018-2019:

- Connecticut – Research on the self-funded/ERISA exemption from state laws.
- New Jersey – Pursue provider network leasing legislation that gives more freedom to dentists.
- North Carolina – Pursue “dental bill of rights” legislation that addressed network leasing, virtual credit card, and prior authorization of payment.
- Oklahoma – Pursue legislation addressing prior authorization of payment and virtual credit card.
- Virginia – Pursue network leasing legislation.
- Wisconsin – Pursue legislation addressing any willing provider, assignment of benefits and network leasing.

Each of the state associations reported monthly to FIIST concerning the success of their advocacy campaign and how member dentists were being engaged. Bills became law in three states (North Carolina, Oklahoma and Virginia) with a bill nearing passage in New Jersey (as of this writing). The associations were also asked to evaluate the impact SPA funds made in their success. All responding associations reported that SPA funds increased the effectiveness of their campaigns, either through hiring additional lobbyists (Oklahoma and New Jersey), more effective communications to members (North Carolina and New Jersey), and more capacity for direct lobbying (Virginia).

## Findings and Recommendations

Based on early results from the pilot projects, augmenting state association advocacy efforts with SPA funding appears to improve the chances of success. Though the impact on association membership and membership satisfaction with ADA efforts has yet to be determined, state associations involved in pilot projects actively engaged their membership in grassroots efforts and informed their membership of success throughout the projects. Because third party payer issues are top-of-mind for dentists, FIIST anticipates that communicating about association actions taken to address third party payer issues will have a positive impact on membership.

FIIST recommends a national campaign where SPA funds are dedicated to the top five third party payer issues that were both identified in the Taskforce survey and that showed success in pilot projects. The recommended top five priority areas are: Assignment of Benefits, Provider Network Leasing, Virtual Credit Card-EFT Payment Regulations, Prior Authorization Payment Guidelines/Requirements and Retroactive Denial-limiting the time allowed for carriers to request overpayment refunds. FIIST notes that additional issues may warrant consideration, and in the future the SPA Oversight Workgroup has discretion to add issues, such as the practice by some carriers of “disallowing” claims and “missing tooth” clauses.

Nationwide success on these issues addresses “pain points” for dentists and builds momentum on previous successes. State-based success can also be leveraged to address these issues at the national level. The Department of State Government Affairs will have well-developed toolkits on these issues prepared for the 2020 state legislative sessions. FIIST also asks the ADA to consider branding this nationwide effort within the next two years to effectively communicate our success to members and potential members.

FIIST further notes that SPA grants need not be limited to legislative efforts. Rather, the grants can also be used on PR campaigns to highlight the success an individual state association has had on one of the top five issues, can be used by multiple associations to undertake a regional PR effort on one of the top five issues, or can be used to communicate an unfair insurer practice that harms the public and dentists.

In response to these recommendations, the ADA Board appropriated an additional \$600,000 to the SPA budget for 2020 to be used for third-party payer initiatives. Accordingly, because the expanded program is already included in the 2020 proposed budget, no resolution is proposed or needed. This report is informational.

## Resolutions

This report is informational and no resolutions are presented.

**BOARD RECOMMENDATION: Vote Yes to Transmit.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

Resolution No. None N/AReport: Report of the Election Commission Date Submitted: July 2019Submitted By: Election CommissionReference Committee: D (Legislative, Health, Governance and Related Matters)Total Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

**REPORT OF THE ELECTION COMMISSION: RESPONSE TO THE REFERRAL OF RESOLUTION 89-2018**

**Background:** In 2018, the Election Commission proposed an overhaul of a substantial portion of the rules and guidelines under which campaigns for elective office are conducted. The revision combined the Election Commission and Campaign Guidelines typically published in the supplemental information that accompanies the annual Manual of the House of Delegates and aspects of the campaign agreements that prior to 2018 were negotiated between candidates for President-elect. The House of Delegates, with an amendment not relevant here, adopted the revised Election Commission and Campaign Rules (Resolution 24H-2018, *Trans.*2018:366) (hereafter “campaign rules”). While many aspects of the campaign rules were revised pursuant to Resolution 24H-2018, one area that stayed substantially the same were the rules concerning the candidates’ travel to constituent society and trustee district meetings.

In the open hearing before the reference committee that considered the resolution to amend the Election Commission and Campaign Guidelines, the committee heard a substantial amount of testimony concerning the high cost of conducting a campaign for elective office, principally because of the cost incurred by President-elect candidates traveling to district caucuses and state meetings. Concern was also expressed about using constituent dues dollars to finance candidates’ campaigns. In light of that testimony, the reference committee proposed Resolution 89, calling for a study of campaign travel. The background statement that accompanied Resolution 89 contained the following explanation:

During the discussion of Resolutions 24 and 24S-2, there was considerable testimony regarding the expense of conducting a campaign for President-elect, principally because of the cost of the travel associated with visiting constituent and trustee district meetings throughout the country. The Reference Committee believes that the time has come to study this issue with the goal of reducing or eliminating campaign travel and replacing that travel with more economical means of introducing candidates to delegates, alternate delegates and members of the Association, such as video conferencing. Exploring ways for trustee districts and delegates to better prepare for voting for the President-elect of the Association while at the Annual Meeting should also be considered. Reducing or eliminating campaign travel expenses would also serve to minimize the issue of using constituent and component dues dollars to fund campaigns, an issue that is addressed by Resolution 24S-2, about which testimony was also received by the Reference Committee.

As passed by the House of Delegates, Resolution 89 reads as follows:

**Resolved**, that the appropriate agency study options such as video conferencing and town halls, and make recommendations on campaign travel to trustee districts without compromising the ability of delegates to select the candidate who they believe will best fill the position of President-elect of the ADA, and it is further

**Resolved**, that the results of the study be reported to the 2019 House of Delegates.

Following the 2018 House of Delegates, it was determined that the Election Commission was the “appropriate agency” to conduct the study and report to the House. To facilitate the collecting of information deemed necessary to complete the study, the Election Commission formed a campaign travel task force composed of former ADA Presidents, a former candidate for President-elect and representatives from two trustee districts that appeared to have a great deal of interest in lowering the cost of campaigns and of identifying alternatives to in-person candidate presentations to assist delegates in developing knowledge of the candidates and their positions on issues.\*

The task force is thanked for their dedication and diligence in examining this issue and the task force members’ work is gratefully acknowledged.

#### **Discussion:**

Methods of Communications Presently Allowed under the Campaign Rules. At the outset it is important to remember that the 2018 amendments to the campaign rules substantially broadened the ways by which candidates may communicate with delegates, alternate delegates and members. Prior to the revisions adopted by the House in 2018, communication between candidates and members, delegates and alternate delegates was limited to:

- Profiles and statements published in the ADA News and then posted on ADA.org and the area on ADA Connect dedicated to candidates for elective office;
- Distribution of printed campaign literature at each House of Delegates session\*\*; and
- By invitation, visits to state and/or district annual meetings and/or leadership conferences and annual session district caucus meetings, with 2nd Vice President and Speaker of the House candidates’ visits being limited to annual session district caucus meetings.

Prior to this year, visits to state and district meetings were usually subject to limitations in addition to those contained in the campaign rules. Those additional restrictions were negotiated each year by the candidates for President-elect and memorialized in the candidates’ campaign agreement. Because the campaign agreements were negotiated each year, the additional limitations varied but usually involved acceptance of an invitation to appear at a meeting only when either a majority or all the candidates were able to attend.

For convenience, a copy of the current Election Commission and Campaign Rules is appended to this report as **Appendix 1**. With the revisions to the campaign rules adopted by the House of Delegates in 2018, and particularly the inclusion of paragraph 7(d), the candidates cooperate to develop a mutually acceptable travel schedule. With one exception, if a majority of the President-elect candidates can accept a state or district caucus invitation, they may do so, even if other candidates have conflicts. The exception relates to a schedule conflict caused by a religious holiday, where the conflict of a single candidate results in all candidates declining the invitation. The next paragraph, 7(e), allows a candidate

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\* The travel task force members were Dr. Joseph P. Crowley, Dr. Gary Roberts, Dr. Andrew Kwasny, Dr. Richard Rosato and Dr. Thomas Raimann.

\*\* In fact, just prior to the 2018 House of Delegates, the laying down of campaign brochures at the House of Delegates was eliminated in favor of electronic copies of campaign literature being posted online.

who declined an invitation due to a scheduling conflict to participate in the meeting by audio or audiovisual means available to both the candidate and meeting host.

The 2018 revised campaign rules allow candidates to use additional avenues by which to communicate to members, delegates and/or alternate delegates, some of which previously were negotiated between candidates via their campaign agreements and some of which have been revised:

- The distribution of campaign brochures at the House of Delegates has been revised; hard copies of brochures are no longer distributed. Rather, candidates can distribute campaign literature electronically to delegates and alternate delegates twice during the campaign (**Appendix 1**, paragraphs 17-18);
- A campaign video may be distributed to delegates and alternate delegates (**Appendix 1**, paragraph 19);
- Each candidate may communicate a single time to each delegate and alternate delegate via email (**Appendix 1**, paragraph 21); and
- Each candidate's campaign may initiate a single telephone call to each delegate and alternate delegate (**Appendix 1**, paragraph 22).

Finally the campaign rules adopted by the House of Delegates in 2018 authorize two technology-based ways of communicating with delegates and alternate delegates that were previously not allowed under the former campaign guidelines:

- Each candidate is permitted to schedule up to three (3) telephone forums or town halls during the campaign; the ADA will assist in publicizing each event by announcing the telephone town hall event information to delegates and alternate delegates via ADA Connect and providing the information to Election Commission members and staff (**Appendix 1**, paragraph 24); and
- Under the new campaign rules, each candidate is permitted to provide candidate and campaign issue information to delegates and alternate delegates via a closed Facebook group page (**Appendix 1**, paragraph 14).

Against the backdrop of the new campaign rules, the task force set out to investigate whether other mechanisms could be employed that might assist delegates and alternates in determining which candidate they believe would best fill the position of ADA President-elect so that the travel candidates currently undertake could be diminished or eliminated.

The Research of the Campaign Travel Task Force. In order for the task force to fully understand the question posed to it by the House of Delegates, it was necessary for the task force to understand how campaigns from the trustee districts are funded. The task force was also interested in details of when and where trustee districts meet and caucus before the ADA House of Delegates annual meeting to which President-elect candidates are invited; questions were also asked to elicit if opportunities exist for districts to meet together to lower the money spent visiting district caucuses by candidates. The questions posed to the trustee districts together with the responses received has been assembled as **Appendix 2** and is forwarded with this report. Key takeaways from those responses are summarized below:

- Importance of Candidate Visits (**Appendix 2**, page 14, question 11). Obviously, one key question is how important the in-person President-elect candidate visits are to the trustee districts; if the visits are not perceived to be helpful, curtailing spending on travel might be viewed as a viable and attractive option. The responses received indicate that only two districts feel that the in-person candidate meetings are relatively unimportant (responses of 1 or 2) and, of those two, one district indicated a split between its delegation, with some viewing the time spent with candidates as very

important and the remainder feeling a pre-House meeting with candidates was not important. Two districts viewed the candidate meetings as somewhat important (3), while the remaining districts responded that the pre-House meetings with candidates were important (4) or very important (5).

From the responses received, it appears that for most districts, district caucuses are the only events that offer the opportunity for delegation/candidate engagement, although a few districts issue invitations to state annual meetings (**Appendix 2**, page 10, question 7). All trustee districts that responded reported that candidates are invited to visit in-person with the caucuses (**Appendix 2**, page 7, question 6A). However, it should be noted that some caucuses only issue invitations to candidates to visit during meetings held at the Annual Session. Nine districts reported that they extend one invitation to President-elect candidates, while the remaining responding caucuses issue two invitations (**Appendix 2**, page 6, question 6). Candidates spend anywhere from 15-20 minutes to one to two days meeting with the district caucuses (**Appendix 2**, page 5, question 5), with the visits being anything from campaign-related presentations only to a mix of social and campaign-related activities (**Appendix 2**, pages 8-9, questions 6B and 6C).

- District Meeting Timing and Locations. As for those districts that reported when their pre-Annual Session caucus meetings occur, the majority reported that the caucuses are held within a month of the Annual Session, with some indicating two to three weeks prior to the convening of the House of Delegates (**Appendix 2**, page 1, question 1). This makes sense, as the second set of resolutions reviewed by the caucuses are forwarded by ADA Headquarters staff to the districts after the Board of Trustees meeting that immediately precedes the House of Delegates session.

In terms of locations, thirteen districts require delegates to attend the meeting in person, two convene by conference calls and two meet in person but allow participation via conference call or video conference (**Appendix 2**, page 2, question 2). While a few of the multi-state districts and one single state district rotate their meetings among venues within the district, most responses indicate that meetings are held at locations that are relatively accessible by air (**Appendix 2**, page 3, question 3 and page 15, question 12). Some districts responded that moving the venue of a caucus would be considered to make visiting the caucuses by candidates more efficient and less time consuming. Other districts, citing logistics, the convenience of delegates or cost, declined to consider moving their traditional caucus venues (**Appendix 2**, page 16, question 12A).

- Reasons for not Inviting Candidates to pre-Annual Session Meetings. Given the overwhelming response that meeting with the candidates is deemed to be very important, it is critical to understand why some trustee districts no longer invite candidates to meet with them at pre-Annual Session meetings. That information is summarized in the table of responses to Question 8 (**Appendix 2**, page 11). The reasons given range from no longer having an in-person meeting (Trustee Districts 3 and 13) to scheduling conflicts or that the timing of the meeting precludes an invitation (Trustee Districts 4 and 7), to difficulties in scheduling and time constraints (Trustee District 9) and the costs outweighing the benefits (Trustee District 10).

- Videoconferencing Capabilities in the Trustee Districts. With an eye toward the possibility of exploring the opportunities that technology might present for less expensive ways to facilitate communications between candidates and the District caucuses, the survey of the trustee districts asked for information concerning the technology currently used to foster communications within districts. As might be expected, a wide variety of responses were received (**Appendix 2**, page 4, question 4). Five districts indicated conference calls are utilized. Three districts responded that some sort of video conferencing capability is used. The remainder did not provide information, mostly because the district caucuses meet in person and communications technology isn't required. Along with requesting information concerning technology *currently* used, the survey also solicited data regarding the *capability* to use videoconferencing for communicating about district business (**Appendix 2**, page 12, question 9). Nine districts responded that they either use or have the ability to use videoconferencing, three districts indicated that using videoconferencing is possible but has

not been utilized, and the remaining five districts responded that the capability for communicating via videoconferencing does not presently exist.

- Finally concerning the issue of meeting and communicating with candidates, the districts were asked to provide their ideas for alternatives to candidates traveling to pre-session caucus meetings so that delegates can become familiar with the candidates and their campaign platforms (**Appendix 2**, page 13, question 10). Thirteen of the seventeen trustee districts provided suggestions. All but two of the suggestions embraced the use of video technology in some fashion. Seven of the responses mentioned videoconferencing or video streaming. While many of those comments generically referred to videoconferencing, one District's comments suggested that candidates use a professional studio having high quality audio and video capabilities, such as the studio located in the Headquarters Building in Chicago.\* Other responses included suggestions for video presentations, videos of candidates each answering the same questions and video meetings with each delegation. The Thirteenth District suggested a single online forum at which all candidates would present their platforms and then respond to questions submitted either online or prior to the start of the forum.

Some of the responses requesting technology suggestions added cautionary comments – the comment from the Second Trustee District is illustrative, where the district expressed the opinion that videoconferencing would not be nearly as effective as live, in-person visits to delegations. The Twelfth Trustee District echoed similar sentiments, stating that face-to-face interaction both formally and socially has great advantages.

The Underlying Issue of Financing a Campaign for Elective Office. As recounted above, one of the concerns that resulted in Resolution 89-2018 is the use of constituent and component dues dollars to finance campaigns. Consequently, it was felt that investigating how campaigns of candidates for ADA President-elect are financed might be of interest to the House of Delegates as it considers whether the present system of candidates traveling to meet delegates, present their campaign platforms and respond to delegates' questions should be replaced or modified.

Trustee districts were asked to describe their level of financial support of President-elect candidates from their districts according to one of three levels – (1) No financial support from the Trustee District or state or local dental societies within the district; (2) Voluntary donations from the Trustee District and state and local dental societies within the district are permitted; and (3) the Trustee District and state and local dental societies within the district completely fund the candidate's campaign. The responses received are summarized in the chart found at **Appendix 2**, page 18, question 14.

The responses indicate that several trustee districts and state societies prohibit using dues dollars to fund candidates' campaigns. For example, the Sixteenth Trustee District reported that no district, constituent or component campaign contributions are allowed. The Eleventh Trustee District also stated that it does not directly contribute to campaigns. Wisconsin reported that state association policy prohibits constituent money from funding election campaigns but that some components of the state association have contributed to candidate's campaigns. On the other end of the spectrum, two trustee districts, the First and the Thirteenth, reported that they fund the total cost of the campaigns of President-elect candidates running from their districts.

While there are some inconsistencies in the responses received, it appears that at least ten trustee districts support "favorite son and daughter" candidates by providing campaign funds. Most of the responses indicate some level of voluntary financial involvement in campaigns by the candidates' home trustee districts and constituents within the district.

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\* Per policy, ADA staff is prohibited from assisting candidates in matters relating to their campaigns.

1 The questionnaire sent to the trustee districts also requested information from those who do contribute  
2 campaign funds to describe how the contribution amounts are set (**Appendix 2**, page 19, Question 15).  
3 Turning first to the districts that totally fund campaigns, the First Trustee District reported that a formal  
4 vote to support a candidate is taken; if supported, the full cost of the campaign is divided among the  
5 district's delegates. The Thirteenth Trustee District (California) reported that it has a designated  
6 campaign fund in an amount determined by the constituent's board of trustees and that is replenished  
7 from operating reserves when necessary. Spending from the fund requires board approval.

8 For the districts that report making some level of funding available to candidates, the mechanisms for  
9 setting contribution amounts vary. Some trustee districts report that the amounts are totally voluntary; the  
10 response of the Second Trustee District, for example, states that the contributions are entirely voluntary  
11 and that the components (called "districts" in New York) each decide on the level of support provided.  
12 Other districts report that contributions are set by vote (the Fifth and Twelfth Trustee Districts), or formula  
13 (Fourteenth Trustee District).

14 **Analysis.** Having provided a discussion of much of the work and factual material underlying this report,  
15 the report will now present alternative methods that have been identified that could be used or adopted to  
16 reduce the cost of campaigns by reducing the quantity of campaign travel (and consequently lowering the  
17 cost of conducting a campaign for President-elect). It is possible that by employing one or more of the  
18 alternatives identified, campaign travel could be entirely eliminated by requiring the candidates to use the  
19 technology-based alternatives to communicate with Trustee District delegations in place of the current  
20 system of personally visiting delegations and constituent leadership upon invitation.

21 This report will present and discuss several alternatives to the system currently in place. Before doing so,  
22 however, it must be noted that there are some possible drawbacks to reducing or completely eliminating  
23 the ability of candidates for President-elect to travel to personally meet with trustee district delegations.  
24 During the course of examining this issue, several past officers and candidates stated that the current  
25 system of campaign travel to personally meet and interact with delegations over the months leading up to  
26 the election was very valuable, in that the experience of making multiple presentations to live audiences  
27 made them far better and more effective speakers than when they began. The view was expressed by  
28 former officers and candidates that visiting with the delegations during the campaign season allowed the  
29 candidate who ultimately won the election to better represent the ADA in a polished and professional  
30 manner. Curtailing the present system of campaign travel to meet with district caucuses would deprive  
31 candidates of that valuable practice.

32 Also, as can be seen from some of the comments summarized in **Appendix 2**, some of the caucuses  
33 expressed the belief that communicating with candidates remotely is a poor substitute for meeting face-  
34 to-face. This caution should be kept in mind when considering possible changes to the present system of  
35 campaign travel, particularly in light of the admonition that any revisions to the campaigns be undertaken  
36 "without compromising the ability of delegates to select the candidate who they believe will best fill the  
37 position of President-elect of the ADA."

38 Revising the Methods of Financing Campaigns. As noted above, it appears that Resolution 89-2018  
39 arose, at least in part, because some delegates are sensitive to the use of dues dollars to fund individual  
40 political campaigns. But as the survey responses appended to this report as **Appendix 2** indicate, many  
41 Trustee Districts and constituents provide no societal or delegation campaign financial support to  
42 candidates. Rather, candidates from those districts rely on voluntary contributions from individual ADA  
43 members (perhaps together with the candidates' own funds) to defray the costs of running for office.

44 To the extent that Resolution 89-2018 arose from a concern over using constituent dues dollars to  
45 partially or fully fund individual campaigns, that concern could be alleviated by revising the campaign  
46 rules that relate to the financing of campaigns. Currently, paragraph 27 of the campaign rules govern the  
47 allowed source of contributions to fund a campaign:

27. Contributions (including money and in kind services) are acceptable only from individual dentists, family members and ADA constituent and component dental societies, which includes component branches and study clubs recognized as part of the constituent society. Contributions from any other sources are not permissible. No candidate will knowingly accept campaign contributions which create the appearance of conflict of interest as reflected in the ADA Bylaws.

The rules could be amended to delete reference to constituents and components (including branches and study clubs) as being permissible sources of funds to support a campaign for elective office. This would have the effect of allowing only voluntary contributions from individual dentists and candidates' family members. Such a change would extinguish concerns over the use of dues dollars to fund campaigns for elective office. Of course, this would put the onus of raising funds to support a campaign completely on a candidate, but that does not appear to be an insurmountable task; raising \$50,000 would require 1,000 contributions of \$50 each out of a member population of over 160,000 dentists. Indeed, shouldering the responsibility for raising all the funds required to mount a campaign for ADA elective office might result in candidates voluntarily adopting more efficient means of campaigning.

Minimizing Campaign Travel to Reduce the Cost of Campaigning. One way of reducing the amount of money spent on campaign travel while still affording opportunities to personally interact with the candidates is to combine caucus meetings or strategically arrange meeting times and locations to allow visits to multiple caucus meetings by the candidates on the same trip. Looking solely at geographic proximity, it appears theoretically possible to arrange for meetings of adjacent district caucuses (for example, the Seventh, Eighth and Ninth Trustee Districts) at a single venue. Coordinating caucus meetings of the three trustee districts to simultaneously occur in a single city readily accessible to the candidates by air would allow candidates to visit each meeting by traveling to that one city, rather than requiring travel to three different cities to accomplish the same objective. It should also be noted that combining meetings in the same locations on the same or adjacent dates might allow candidates to interact with delegates they might not otherwise be able to meet because of conflicting schedules or the sheer lack of time to meet with every delegation.

There are drawbacks to this scenario, however. A great deal of cooperation and collaboration between the participating trustee districts would be needed to successfully coordinate meetings. The trustee district responses included in **Appendix 2** shows some reluctance to consider change. Also, even if the coordinated meetings were rotated between cities each of the participating districts (Milwaukee or Detroit, Chicago, and Indianapolis or Columbus, in the example given), it might be marginally more expensive for the delegations than is presently the case. This might be negatively perceived as shifting the cost of campaigning to the delegations from the candidates' campaigns, but the prospect of allowing personal interaction with a greater number of delegations than is now the case might be sufficient to justify the incremental expense incurred.

A Hybrid System of Personal Travel and Use of Technology-Based Communications Is Already Permitted by the Campaign Rules. As indicated above, the current version of the campaign rules adopted by the House in 2018 contain two newly permitted avenues for candidates to communicate with delegates – up to three telephone forums or town halls and candidates setting up closed Facebook group pages that could be used to host webinars on campaign topics, video chats and other mechanisms by which delegates could form impressions of candidates and their platforms. Because both the town halls and closed Facebook group capability are permitted under the current rules, there is no barrier against either being adopted now. However, perhaps because there is only a single individual who has announced as a candidate for President-elect, those tools remain unused.

Finally, amending the present system of campaign travel that exists might result in a reduction of travel expenses. For example, the campaign rules could be amended to allow only for a finite number of trips to meet delegations with the remainder of delegation contacts to be made via the permitted telephone town halls and closed Facebook group communications. If such a hybrid system were to be adopted, it would

also be possible to codify a system of rotating visits to districts that desire personal candidate visits so that no one trustee district would be visited every year while others might not be visited at all.

New Technologies to Reduce or Take the Place of Personal Visits to Delegation Meetings. This report has already mentioned the use of telephone town halls and closed Facebook groups that could be utilized by candidates seeking to interact with Trustee District delegations. There are other technologies and sources – notably, video technology – that could be utilized by candidates to take the place of some or all of the personal pre-annual session personal meetings by district caucuses. These will be summarized below:

- One of the simpler technologies that could be employed is utilizing a videoconferencing solution through which a candidate could make a presentation that would be streamed to a video screen during a delegation meeting. Employing such a system would allow for both candidate presentations and question and answer sessions between candidates and the delegation. Video conferences could also permit events organized like town halls or forums to occur. This solution could even be deployed in those districts that hold only conference or video call meetings. There are several different videoconferencing platforms available; the one that was mentioned several times in the survey of district delegations and that seems to be generally known by delegations and constituents is the Zoom video conferencing service.
- Video town halls facilitated by third party vendors are also available. These services can be configured where the service will connect participants whose identities have previously been provided to the service. Video conference town halls can also be constructed so that the participants connect with the town hall facilitator via an internet link alone or in conjunction with a separate telephone connection. These services may also allow questions for the candidate to be presented ahead of time, so that the questions can be logically organized into subjects and screened for potentially inappropriate or irrelevant content. Some services offer to provide a moderator who will announce participants in a live town hall format or read questions when questions are solicited ahead of time. The video town hall can also be recorded so that the event can be posted online upon completion of the event.
- Another use of video technology has already been used by candidates over the past several years is the preparation of videos to introduce candidates. Up to now, the videos have been short and are made available to delegates and alternate delegates via posting online on a platform such as YouTube or Vimeo. As noted in **Appendix 2**, one of the suggestions made by the district delegations is for candidates to expand the use of videos so that they include material about the candidate's position on issues and plans for her or his tenure while leading the ADA.
- Another possible use of video technology would be to have video recordings of each candidate being interviewed using the same series of questions. The questions could be solicited from the trustee district delegations and individual members. These videos would allow the delegations to make an "apples to apples" comparison of each candidate's stance of issues as well as viewing each candidate's demeanor and presence while being videotaped.
- Yet another possibility using video technology to facilitate candidate/member communication and interaction is to stage a video debate that includes all President-elect candidates. The structure of the debate might mimic a U.S. presidential debate where candidates would provide short opening and closing statements and respond to questions posed by one or more moderators. There are many potential variations on the format, including allowing candidates to reply to answers given by another candidate. The debate could be streamed over the internet so that those interested could watch the debate in real time. The debate video could also be posted for later viewing. The format would allow for the solicitation of questions from delegations and membership prior to the debate so that questions of particular interest would be aired. Questions could be reviewed and sequenced according to, for example, subject matter. In addition to (or

instead of) using questions submitted prior to the debate, the format could be structured to allow debate viewers who wish to submit questions to do so via an online chat feature or by telephoning the debate venue. Those questions could then be provided to the moderator for incorporating into the debate.

Information Concerning the Cost of Employing Technologies to Supplement or Take the Place of Personal Candidate Travel to Delegation Events. Obviously, the cost of utilizing technology to foster communication between candidates and delegates depends on the how the technology is used and what particular technology is deployed. Until the precise details concerning what technology is used and how it is used, it is impossible to provide precise cost estimates. However, the campaign travel task force, with the assistance of the ADA IT and Integrated Marketing and Communications staff, has gathered some cost information in order to provide data that should allow the House of Delegates to develop an appreciation of the potential costs involved in for each of the alternatives presented.

#### Alternatives Currently Allowed Under the Campaign Rules.

- Telephone Town Halls: Attached as **Appendix 3** is a spreadsheet that provides cost information for three different vendors of telephone town hall services. A two hour telephone town hall event for approximately 100 participants (i.e., 120 minutes x 100 participants plus a candidate = 12,120 minutes) would cost roughly \$1,500 using Telephone Town Hall Meeting service if the service facilitated connection with participants (outbound), and would cost approximately \$1,200 if the participants dialed into the town hall event (inbound). Stones' Phones, another town hall event facilitator would be slightly more expensive for outbound calling (\$2,050) but would cost about the same for inbound calling. The third vendor included in the cost analysis, Contact Group USA, would be significantly more expensive when outbound calling is used (\$8,450) and also when inbound calling is chosen (approximately \$1,800) (12,120 minutes x 0.15 per minute). Two of the telephone town hall services also provide video streaming of the town hall event, and various other options (e.g., question screeners, training on the use of the platform) are available depending on the vendor selected for the additional fees noted in **Appendix 3**.

It should be noted that a telephone town hall event can be created without an outside vendor utilizing a videoconferencing platform such as Zoom or ReadyTalk. The use of these types of platforms may be somewhat cumbersome if participants are individually connecting to the event, but much less so if the videoconferencing platform is used to connect a candidate to a delegation meeting, where the candidate's image could be displayed on a large video screen at the delegation meeting site. Cost estimates for two video conferencing platforms – ReadyTalk and Zoom – are provided as **Appendix 3**. It is difficult to compare the costs of the two services because the pricing models are different. ReadyTalk costs, like the telephone town hall services previously discussed, scale based on the number of total minutes used per event, and provides relatively inexpensive event assistance (\$150 per event). Zoom's pricing model has a more expensive event fee than ReadyTalk, but that fee does not increase (up to 500 participants) based on how many participants are involved in the event. As a benchmark, for one event of 90 minutes duration having 100 participants, the cost of utilizing ReadyTalk would be \$411 and the cost of using the Zoom platform would be \$665. If the number of participants increased to 250, the cost of using ReadyTalk would increase to \$803, while the Zoom cost would remain constant at \$665.\*

- Video Studio Costs. The cost of renting a soundstage on which to shoot a video varies widely depending on the location and facility. Conservatively, two days of soundstage time would be

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\* In addition to the cost of the videoconference platform, there would also be a charge for providing a video monitor or projector if a delegation meeting was held at an offsite venue, but it is assumed that such technology would already be present at the meeting and that the expense of providing that equipment is de minimis.

needed to accommodate set-up, rehearsal, holding the event and tear down. Three examples of soundstage rentals that are provided for illustrative purposes only are:

Dreamworld Studio, Minneapolis -- \$600 per day / \$1,200 total for 2 days

Motion Source Video, Chicago -- \$800 per day / \$1,600 total for 2 days

Victory Studio Seattle -- \$850 per day / \$1,700 total for 2 days

Of course, the soundstage rental is just the tip of the iceberg in calculating the cost of shooting a video or hosting an event like a debate. Lights and cameras would need to be rented if not included as part of the soundstage rental fee. Following are some of the other costs identified by staff from the ADA Integrated Marketing and Communications Division to be considered if filming an event or a professional quality candidate video is being examined:

Expense Item	Rate	No. of Hours	Cost
Director - manages cameras/filming for rehearsal and day-of filming	\$150/hour	20	\$3,000
Producer - scripting, logistics, coordination of all details - sets, lighting, sound, hair, makeup, rehearsal	\$100/hour	80	\$8,000
Lead Videographer - Staffing video camera for rehearsal and day of filming, lighting support, set-up and prep	\$150/hour	40	\$6,000
Additional Videographers - up to 5 cameras/videographers in the room to capture candidates + wide shot (16hrs each x 5 people)	\$150/hour	80	\$12,000
Post Production Editor	\$85/hour	40	\$3,400
Set design/props/podiums			\$2,000
Hair/Makeup			\$1,000
Music for Intro			\$100

Expense Item	Rate	No. of Hours	Cost
Moderator – Facilitates event, contributes to scripting / curates questions	\$65/hour	20	\$1,300
Post Production Designer - (backdrops, lower third templates, end page CTA	\$50	16	\$800
Catering			\$2,000
Total			\$39,600

All together, the cost of filming an event such as a debate or candidate forum could approach \$50,000. Even if it was decided to post the video without any post production editing and the videography costs were reduced by 50%, the cost of staging the event would approach \$30,000. A candidate video that would not require multiple videographers would also be less. While the estimated cost of producing a video of an event or a candidate video is perhaps surprising, if such an event or candidate videos were to take the place of multiple candidates making in-person visits throughout the country, it would appear that a cost savings might be realized.

**Conclusions.** While Resolution 89 requests that “recommendations on campaign travel to trustee districts without compromising the ability of delegates to select the candidate who they believe will best fill the position of President-elect of the ADA” be provided, the only recommendation that the Election Commission believes is appropriate to make at present is that any wholesale revisions to the current method of campaigning for President-elect of the ADA are premature because:

- The Election Commission believes that restricting or preventing the candidates from personally visiting Trustee District delegations and constituent annual meetings to make campaigning for President-elect more economical will result in candidates who are less prepared to assume the responsibility of being a polished and professional face of the ADA to the public upon election. Perhaps that potential deficiency could be overcome by the elected individual being coached and trained in public speaking, but the potential downside of negating opportunities for candidates to practice and hone their public speaking abilities before fellow ADA members needs to be carefully considered and weighed by the House of Delegates before such a step is undertaken.
- The current campaign rules permit each candidate to schedule up to three telephone town hall events and provide a closed Facebook group page accessible to ADA delegates and alternate delegates.\* It is presently not known if these mechanisms could provide acceptable alternatives to personal campaign appearances. Because only a single individual has announced his candidacy for President-elect this year, these campaign tools have not been utilized. The Election Commission believes it is prudent to allow candidates to utilize the new campaign tools provided by the 2018 amendments to the campaign rules adopted by last year’s House of Delegates before embarking on any revisions to the current system of campaign travel because such revisions may well adversely affect the ability of delegates to form opinions on which candidate would be the best choice of leading the ADA.

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\* The Election Commission would support an amendment to the campaign rules that would broaden the current rule allowing three telephone town halls by deleting the restriction of the number of events permitted and by allowing video town hall events.

- Given that a significant amount of the debate leading to the adoption of Resolution 89-2018 was grounded by the concern over use of members' dues dollars to fund campaigns for elective office, perhaps an alternative solution to curtailing the expense of campaign travel should be considered and debated by the House of Delegates. The House may wish to consider amending the campaign rule to allow candidates to accept campaign contributions only from family members and voluntary member contributions.

Resolution 89-2018 raises issues that are complex and it is unclear that any technology solution exists that can provide an equal opportunity to form opinions on candidates for President-elect as does the present system of candidates' in-person visits to delegation and constituent meetings. The House should carefully consider the alternatives presented here and carefully weigh if any benefits derived from restricting in-person campaign visits are worth the potential drawbacks that have been identified in this report.

### Resolution

This report is informational and no resolutions presented.

**BOARD RECOMMENDATION: Vote Yes to Transmit.**

**BOARD VOTE: UNANIMOUS. (BOARD OF TRUSTEES CONSENT CALENDAR ACTION—NO BOARD DISCUSSION)**

# Election Commission and Campaign Rules

The Election Commission is composed of three members: the immediate past President, and the chair and vice chair of the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). The chair of CEBJA serves as the Election Commission chair. The Speaker and the President-elect's campaign manager or appointee will serve as consultants to the Election Commission, each without the right to vote. Except as provided below, in the event that one of the members is unavailable, a replacement member will be selected by the chair of the Election Commission in consultation with the Election Commission. In the event that the chair is unavailable due to a conflict with a candidate, the vice chair of CEBJA shall serve as chair and shall appoint a replacement member in consultation with the Election Commission. In the event that both the chair and vice chair of CEBJA are unavailable due to conflicts with a candidate, the senior class of CEBJA shall select replacement members and the chair of the Election Commission.

The Election Commission is charged with (1) overseeing and adjudicating contested issues arising under the Election Commission Rules Governing the Conduct of Campaigns for all ADA Elective Officers (the Campaign Rules); (2) informing anyone identified as being under a disciplinary sentence of suspension or probation for violating his or her duties to the constituent society within whose jurisdiction the member practices or to this Association that they are ineligible to seek elective or appointive office while under that disciplinary sentence; (3) referring any dispute of eligibility to CEBJA; (4) informing the House of any violation of the Campaign Rules; (5) reviewing and proposing revisions to the Campaign Rules as required; and (6) receiving summaries of campaign revenues and expenses from candidates for all ADA elective offices.

## Election Commission Rules Governing the Conduct of Campaigns for All ADA Elective Officers

The following Campaign Rules govern the announcement and conduct of campaigns for ADA elective officers. These Campaign Rules will be

distributed annually to all candidates, delegates, alternate delegates and other parties of interest. Candidates for elective officers are expected to abide by the Campaign Rules.

## Procedures Concerning Interpretation and Distribution of the Campaign Rules

1. To the extent one or more candidates has a question concerning the interpretation of the Campaign Rules or whether a particular activity is prohibited or permitted under the Campaign Rules, the following procedures shall be followed:
  - a. Prior to contacting the Election Commission concerning the question or interpretation, candidates and/or their campaign managers shall communicate and attempt in good faith to reach a consensus on the question.
  - b. If a consensus cannot be reached:
    - i. The campaign that raised the issue shall contact the Election Commission (copying the other candidates and their campaign managers) via a brief and succinct email, state the question or interpretation that has arisen and that the campaigns were unable to reach a consensus on the issue and provide the campaign's position on the issue presented.
    - ii. Within three business days of the receipt of the email referenced in Paragraph b.i, above, any other campaign desiring to do so shall send the Election Commission a brief and succinct email setting forth that campaign's position on the question or interpretation presented to the Election Commission.
2. Any communications from a candidate to the Election Commission regarding these Campaign Rules shall be submitted to the chair of the Election Commission via email addressed to [electioncommission@ada.org](mailto:electioncommission@ada.org) or by such other means as the Election Commission may from time-to-time specify.

3. It is the responsibility of each candidate to inform their campaign committee members, the constituent Executive Directors within their trustee districts and other constituent staff within their trustee districts who are assisting the campaign of these Campaign Rules within fourteen (14) days of the candidate's announcement of candidacy.

### **Agreements between Candidates**

4. Candidates can negotiate and enter into any agreement concerning the conduct of a campaign for elective officer that does not contravene and is not in conflict with any of the Campaign Rules contained herein; agreements between candidates that narrow any of the provisions of these Campaign Rules or agreements by which the candidates forego any campaign activities permitted under these Campaign Rules are permissible. The negotiation and enforcement of any such agreement will be the responsibility of the candidates. The Election Commission will neither facilitate nor enforce any such agreement.

### **Announcing Candidacy**

5. \*Candidates for President-elect and Second Vice President shall formally announce their intent to run for office on the final day of the annual session immediately preceding their candidacy. A formal announcement shall include, at a minimum, the name of the candidate and an identification of the office being sought. Prior to this formal announcement, candidates may freely campaign within their own trustee districts. Campaign activities outside a candidate's own trustee district shall begin only after the official announcement at the annual session. Candidates for President-elect and Second Vice President not formally announcing their candidacies on the last day of the annual session immediately preceding their candidacy shall not be permitted to campaign outside their own trustee districts but shall be permitted to be nominated for elective office at the annual session of the House of Delegates pursuant to Chapter VI., Section

B.1. of the *Governance Manual of the American Dental Association (Governance Manual)*.

6. Announcements of candidacies for the offices of Treasurer and Speaker of the House of Delegates shall be as stated in Chapter VI. Section B.2. and B.3., respectively, of the *Governance Manual*.

### **Travel and Meeting Attendance**

7. Candidates for the office of President-elect shall limit their campaign travel to attending state and/or district annual meetings and/or leadership conferences and annual session district caucus meetings to which all candidates have been invited. The procedures for attendance at such events shall be as follows:
  - a. Candidates for the office of President-elect may accept and attend any such event in a manner mutually agreed upon but only if all candidates have been invited.
  - b. Candidates for the office of Second Vice President, Speaker of the House of Delegates and Treasurer shall limit campaign travel to attending the district caucus meetings held during the ADA annual session.
  - c. District caucuses and state constituent societies shall issue timely invitations to the President-elect candidates through the Office of the Executive Director.
  - d. President-elect candidates shall negotiate a mutually agreeable travel schedule. It is the responsibility of the candidate and/or the campaign managers, through coordination among the campaigns, to determine the candidates' availability and respond directly to the inviting organizations. Except for conflicts due to a religious holiday observed by one or more of the candidates, candidates shall vote on whether to accept an invitation, with a majority needed to accept; a tie vote will result in accepting the invitation. A religious holiday conflict with a single candidate shall result in all the candidates declining the invitation.

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\* NOTE: Paragraph 5. of the "Announcing Candidacy" Section shall become effective at the opening of the 2019 House of Delegates.

- e. Candidates who have scheduling conflicts prohibiting personal attendance at a district or caucus event may, at their option, participate in the event via electronic audio or audiovisual means available to both the candidate and the event's sponsor.
  - f. After a meeting has been accepted, if an emergency arises and a candidate must cancel their attendance, the remaining candidates may attend as planned. Candidates who cancel their attendance at an event due to an emergency may, at their option, participate in the event via electronic audio or audiovisual means available to both the candidate and the event's sponsor.
8. Caucuses and state meetings are requested to provide an appropriate opportunity for the candidates to meet with their members. It is recommended that such forums be structured to allow:
    - a. All candidates to make presentations;
    - b. Caucuses freedom to assess candidates; and
    - c. Each candidate to respond to questions.
  9. Notwithstanding any of these Campaign Rules, nothing in these Rules shall prevent a candidate from traveling on a personal basis or attending a meeting, conference or other event as an official ADA representative. Campaigning while personally traveling or attending events as an ADA representative is strictly prohibited. When traveling personally or as an ADA representative, candidates shall notify other candidates of such travel as soon as possible once the travel has been scheduled.
  10. Candidates shall not use campaign-sponsored social functions or hospitality suite/meeting rooms on behalf of their candidacy at any regional, national or annual meeting. (This is not intended, however, to limit candidates from holding campaign meetings for the purpose of strategizing.) Campaign receptions are not to be held at the ADA Annual Session. Additionally, a district that hosts a reception during the ADA annual session and is sponsoring a candidate in a contested election shall not host the reception prior to the officer elections; a reception may be held after the election. Prior to the election, candidates shall

not attend events in or visit district hospitality suites. This prohibition shall not apply to a candidate visiting his or her own district's hospitality suite or attending events hosted by their own district exclusively for the district's members.

## **Publications and Media**

11. News articles on and interviews of a candidate are permissible if published by a state dental journal. Online state dental journal news articles on and interviews of a candidate are permissible. Articles about a candidate's intention to run for office are permissible. Articles about why one person would make a better candidate are not permissible.
12. When announcing their candidacy for elective officer, except for the candidate's constituent and component, candidates shall notify all organizations and groups to which they belong of their candidacy and shall request that during the campaign such organizations and groups refrain from distributing or publishing any information or material referencing the campaign or the candidate's candidacy.
13. Candidates shall not participate in interviews on their leadership capacity with leadership or national journals that will be published within the timeframe of their campaign. Candidates shall not knowingly seek to have their name, photo, appearance, and writings published in national trade or non-peer reviewed publications or websites during the campaign, and shall avoid submitting articles in non-peer reviewed paper or electronic publications. Candidates who are participants in a speaker's bureau or earn revenue by speaking nationally or regionally shall avoid all unnecessary self-promotion during the campaign related to national speaking engagements.

## **Use of Social Media**

14. In order to facilitate providing information to delegates and alternate delegates by candidates, any candidate may establish a closed-group Facebook page for purposes of disseminating information about the candidate's campaign and interacting with delegates and alternate delegates concerning campaign-related subjects and issues. Any

such closed-group Facebook page instituted by a candidate shall comply with these Campaign Rules and shall also be governed by the ADA's Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees. In the event of a conflict between these Campaign Rules, the Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees, these Campaign Rules control.

- a. The Election Commission will determine the appropriate administrative settings for the closed-group campaign Facebook page that candidates may use for campaign-related posts. Those settings will be communicated by the Election Commission to the candidates shortly after the candidates announce their intention to run for elective officer.
- b. Only delegates, alternate delegates, campaign staff and Election Commission members and staff shall be invited to join a candidate's closed-group campaign Facebook page.
- c. Shortly after a candidate's candidacy is announced, the ADA will provide the known email addresses of delegates and alternate delegates. Using that list, invitations to join the closed-group page may be issued via email by a candidate who wishes to initiate a closed-group campaign Facebook page. Invitations to join the closed-group page may also be sent to the candidate's campaign staff and shall be sent to members and staff of the Election Commission.
- d. Following the compilation of the list of certified delegates and alternate delegates who will attend the House of Delegates session at which the election will occur, the ADA will send the candidate an updated list of certified delegates and alternate delegates that the candidate may use to send a second closed-group campaign Facebook page invitation so that newly listed delegates and alternate delegates may join the candidate's closed-group campaign Facebook page.
- e. Only material that is relevant to the campaign shall be posted on a candidate's closed-group campaign Facebook page. No posts that are negative to any

opposing candidate or that may be considered to be negative campaigning shall be permitted on the closed-group campaign page. Any candidate who develops a closed-group campaign Facebook page shall be responsible for the monitoring of posts to the page to ensure that posts comply with these Campaign Rules and that the posts are consistent with the ADA's Social Media Policy and the Social Media Posting Protocol for ADA Officers and Trustees.

- f. No surveys or polls shall be used or conducted via a candidate's closed-group campaign Facebook page.
  - g. Interactions between a candidate and delegates and alternate delegates using the candidate's closed-group campaign Facebook page shall not count toward any limits on a candidate's contact with individual delegates and alternate delegates contained in these Campaign Rules.
15. Except for the closed-group campaign activity on Facebook specified in Paragraph 14, above, there shall be no campaigning using any social media platform or application.
  16. Personal, non-campaign use of social media by candidates during the campaign for elective officer is permitted but candidates shall not post information or material relating to the campaign on personal social media sites. Candidates shall review their personal social media site settings to ensure that privacy and security settings are set to allow review and deletion of any third party post, and candidates shall frequently monitor their own personal Facebook pages and other personal social media sites and delete any posts that references the campaign or the candidate's campaign activities or posts that can be tagged for distribution to third party sites.

### **Campaign Literature and Communications to Delegates and Alternate Delegates**

17. No printed campaign-related material may be distributed in the House of Delegates or to delegates and alternate delegates.

18. Candidates may prepare a piece of campaign literature to be electronically distributed to the delegates and alternate delegates following a candidate's announcement of candidacy for elective officer. Such campaign literature shall be sized so that if printed the literature is no larger than four single-sided sheets of 8½ x 11 inch paper. If desired, a second piece of campaign literature of similar length may be electronically distributed to the delegates and alternate delegates following the candidates' receipt from the ADA of the final list of certified delegates and alternate delegates.
19. Each candidate may prepare a video to be distributed as described below to delegates and alternate delegates and other members of the House of Delegates.
20. Each piece of literature and any video developed by any candidate shall be submitted to the ADA for review and approval prior to being distributed. Such literature review may take up to five (5) business days to complete. Video reviews will be completed as quickly as possible but are dependent on the length of the video. The candidates shall obtain permissions to use the likeness or image of any non-familial third party that appears in a piece of campaign literature or in any video. Candidates shall state that such permissions have been obtained when submitting the literature and any video for review. The permission should be retained by the candidates and submitted to the ADA only if requested.
21. Each candidate is permitted to individually communicate with each delegate and alternate delegate a single time via an electronic communication (i.e., email) for the purpose of campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate delegate contact information. A third party vendor may be used to send such electronic communications so long as the privacy of the email addresses and identities of the recipients are maintained and preserved and there is no ability to reply to all the recipients of the electronic communication. At each candidate's option, the candidate's electronic communication may contain the campaign literature and/or video referenced in these Campaign Rules, either by embedding or attaching the literature and/or the video to the electronic communication or by providing a hyperlink or hyperlinks that connect to the literature and/or the video that is stored in a remote location maintained by or on behalf of the candidate.
22. Each campaign is permitted to individually initiate a telephonic communication with each delegate and alternate delegate a single time for the purpose of campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate delegate contact information.
23. Nothing in these Campaign Rules shall prevent a candidate from communicating regarding matters within the specific duties of the candidate's position as an ADA officer, member of the Board of Trustees, task force or workgroup, as long as the communication is strictly related to such responsibilities and is not used for campaigning, electioneering or soliciting votes.
24. Candidates may each schedule up to three (3) telephone forums or town hall events during the campaign. A candidate desiring to hold up to three (3) telephone town hall events shall communicate to the ADA the date of each event and the times at which each such event shall commence and end, together with the instructions and contact information necessary for participants to email and/or call with the questions they would like asked during the telephonic town hall. The ADA will announce the telephone town hall information to delegates and alternate delegates via ADA Connect and provide the information to Election Commission members and staff. Candidates may also publicize the telephonic town halls they sponsor on any closed-group campaign Facebook page that they maintain.
25. The agenda for a candidate's telephonic town hall meeting(s) shall be the prerogative of the candidate, with the candidates being permitted to provide opening and closing statements and whether follow-up questions are permitted. The length of the telephonic town hall event is also discretionary with the candidate.
26. No negative campaigning or negative comments concerning opposing candidates shall be permitted to be made by the candidate or any participant posing questions or making comments during the town hall event. Candidates shall be responsible for

ensuring that a screening mechanism is employed during the town hall event so that broadcasting participant comments or questions that violate this provision is avoided.

## Contributions

27. Contributions (including money and in kind services) are acceptable only from individual dentists, family members and ADA constituent and component dental societies, which includes component branches and study clubs recognized as part of the constituent society. Contributions from any other sources are not permissible. No candidate will knowingly accept campaign contributions which create the appearance of conflict of interest as reflected in the ADA *Bylaws*.
28. The sending of a brief note acknowledging a financial contribution or thanking a host of a campaign event to those contributors or hosts outside of the candidate's district is permitted, as long as no additional campaign message is included. Such thank you notes may be sent on campaign letterhead or a notecard containing the campaign logo; envelopes for the thank you note may contain an identification of the campaign or the campaign logo.
29. Any contribution source that could be interpreted to be a conflict of interest or creates the appearance of a conflict of interest must be reported to the Election Commission and the ADA Board of Trustees. In the event a contribution source is deemed to be a conflict of interest or creates the appearance of a conflict of interest, the candidates will be required to return the contribution.
30. Candidates for all ADA elective offices should submit a summary of campaign contributions and expenses to the Election Commission at the end of the campaign.

## Violations

31. In the event a violation of the Campaign Rules is determined by the Election Commission to have occurred more than fourteen (14) days prior to the House of Delegates convening, then the Election Commission, if it cannot resolve the violation between the candidates, shall post a report of the violation in the House of Delegates section on ADA Connect. In addition, an email reporting on any such violations will be sent by the Election Commission to each certified delegates and alternate delegates with a working email address on file with the ADA on or about fourteen (14) days prior to the convening of the House of Delegates.
32. In the event a violation of the Campaign Rules is determined by the Election Commission to have occurred in the period from fourteen (14) days prior to the convening of the House of Delegates through the elections of elective officers, then the Election Commission, if it cannot resolve the violation between the candidates, shall report those violations to the House of Delegates. The report will be given orally by the Election Commission chair (or a designee of the Election Commission if the chair is absent from the House of Delegates session) at the first meeting of the House. If violations occur after that meeting, and before the election, then a report of such violations shall be read to each caucus by a designee of the Election Commission.
33. In addition to the foregoing notifications of violations, all violations of the Campaign Rules that occur shall be reported orally at the House of Delegates meeting by the Election Commission.

October 2018

### CAMPAIGN TRAVEL QUESTIONNAIRE RESPONSES

1. Other than the on-site meetings held during the ADA Annual Session, how many times during the year does your delegation hold formal meetings?

DISTRICT	RESPONSE
1	Potentially 2 times. One as needed meeting at Yankee in Boston (January) and one that always occurs pre-ADA in Nashua NH approx. one month prior to the ADA.
2	The only time we hold formal meetings as a delegation for the ADA annual meeting is on site. We meet annually as a state delegation every summer.
3	Usually once during the month prior to the ADA annual session.
4	One other time
5	(GEORGIA) GA 2; 9ALABAMA) 3; MISSISSIPPI) 3; 5 <sup>th</sup> District 1
6	Once
7	There is not an all-delegation in-person meeting held prior to the ADA Annual Session. Prior to the ADA meeting, the 7th District holds four conference calls based on ADA reference committee subject matter. Each 7th District delegation member is assigned to participate on only one of those reference committee conference calls.
8	Once in April and a 2nd caucus 2-3 weeks before the ADA meeting.
9	(MICHIGAN) 1 meeting for new and near new delegates orientation via Zoom. 1 meeting for each committee (A,B,C,D) via Zoom. 1 pre-caucus meeting at the Michigan Dental Association. WISCONSIN) The Ninth District has one in-person (pre-caucus) meeting approximately 2-3 weeks prior to the ADA Annual Session.
10	Currently 0
11	One additional meeting two or three weeks prior to the ADA HOD.
12	Once, in august
13	None
14	Our delegation meets once a year.
15	Once.
16	Two Times, once as a state delegation, once as a district.
17	Three plus conference call as needed At FDA annual Session in Jan At FDC in June Caucus a week or two prior to ADA

2. Are the delegates required to travel to a central location, or can delegates attend by conference call, videoconference or other formats?

DISTRICT	RESPONSE
1	Travel
2	N/A for ADA delegates. The delegates at our annual state meeting are required to attend in person.
3	Delegates are required to travel.
4	We meet in an agreed upon, central location
5	(GEORGIA) Must travel 5 <sup>th</sup> DISTRICT: Must Travel
6	Travel to the meeting location
7	Conference call
8	Travel to central location.
9	(MICHIGAN) They have traveled in the past to Okemos, Michigan at the Michigan Dental Association. (WISCONSIN) To prepare for the pre-caucus meeting, our various reference committees meet via conference call and video conferencing.
10	We would offer all options to our delegates. The majority believe face to face discussions bear more fruit.
11	All delegates and alternates travel to a central location for the first caucus meeting. (Our caucus chair, vice-chair, ADA Trustee, and relevant staff do hold videoconference meetings during the planning stages for the onsite meeting.)
12	Travel to central location
13	We hold conference call discussions following the distribution of material (one call for each reference committee resolution set) – usually 2 calls per year per reference committee.
14	Since we are a multi-state district, we meet in one of our member states in rotation in a central location. We have not explored any other formats for attendance.
15	Delegates are required to travel to the designated caucus location.
16	All delegates and alternate delegates are required to travel and attend.
17	Delegates are required to travel to a central location

3. If travel for the delegation is to a central location(s), please provide that location.

DISTRICT	RESPONSE
1	Boston, MA and Nashua, NH
2	N/A for ADA delegates. Our annual state meeting rotates each year to a new location.
3	Harrisburg, PA
4	Usually, Wilmington DE
5	(GEORGIA) Atlanta or Birmingham 5 <sup>th</sup> District: Same
6	Rotates between the states of the 6th district
7	N/A
8	Bloomington, in the middle of Illinois
9	(MICHIGAN) Michigan Dental Association, Lansing, Michigan. WISCONSIN) The Wisconsin delegation travels to Okemos, Michigan for the in-person pre-caucus meeting prior to the ADA House.
10	N/A
11	It is usually held in a major metropolitan area in the state of our ADA Trustee. The 2019 meeting will be in Seattle.
12	Dallas,TX as we hold it in conjunction with 15th dist
13	N/A
14	The 2018 site was Las Vegas.
15	Grapevine, Texas.
16	State meeting is at State Annual Session in Myrtle Beach, SC: District Caucus rotates between states.
17	Jan Tampa Marriott at airport June Gaylord Palms Aug Tampa Renaissance Hotel

4. If one or more meetings are held using technology that substitutes for travel to a central location, please provide the format of the meeting. (videoconference, conference call, or other)

DISTRICT	RESPONSE
1	N/A
2	Conference Calls for the ADA annual meeting.
3	N/A
4	N/A
5	(GEORGIA) N/A 5 <sup>th</sup> District: Same
6	N/A at this time but is being considered
7	Conference call
8	No response
9	(MICHIGAN) Zoom videoconference or they can also call in on Zoom during the conference if internet is not available. WISCONSIN) The actual meeting is in-person (face to face). The reference committees can choose to meet via conference call or videoteleconferencing (i.e. Zoom Meetings).
10	Conference call, with video streaming would be used
11	As noted above, a planning meeting that does not involve the delegates and alternates is held by videoconference.
12	N/A
13	Conference call
14	N/A
15	Does not apply.
16	Conference calls are held only on an as needed basis.
17	Conference Call.

5. How long do your caucus's non-HOD annual session meetings usually last?

DISTRICT	RESPONSE
1	One full day
2	1-1.5 Hours; We usually have two teleconferences per reference committee.
3	½ to 2/3 of a day.
4	5-7 hours
5	(GEORGIA) GA – Usually ½ day. 5 <sup>th</sup> District 1 ½ days
6	1 ½ days
7	One hour
8	April -8:00 am – noon the day following state lobby day. 2nd caucus is 9:00 am – 2:30 pm
9	(MICHIGAN) We arrive the night before for a social event and then meet for meeting the next day, about 6-8 hours. (WISCONSIN) One day. Typically six to seven hours.
10	N/A
11	Friday afternoon from 2 PM to 5 PM, then Saturday from 7:30 AM until around 3 PM.
12	1 day
13	N/A
14	We meet for a day and a half.
15	8:00 AM to 2:00 PM
16	Three hours to two days.
17	Meetings Jan 1 ½ hrs June 3 hrs Aug 3-4hrs depending on ADA agenda

6 Do you currently invite ADA President-elect candidates to any of your caucus events or meetings to present their platforms and answer questions?

DISTRICT	RESPONSE
1	Yes
2	Yes. We usually invite them to our New York State Dental Association annual meeting in the beginning of summer.
3	Yes.
4	Usually
5	(GEORGIA) Yes 5 <sup>th</sup> District: Yes
6	Yes
7	Candidates are invited to the 7th district full day caucus meeting held prior to the ADA election to present their platforms and answer questions.
8	They are invited to dinner with the ISDS officers the night before the 2nd caucus and they then are the first thing on the 2nd caucus agenda to present to the delegation. They are also invited to a Q&A session on Sunday onsite.
9	(MICHIGAN) Yes, to pre-caucus at Michigan Dental Association And our on-site caucus at the ADA meeting There has not been one to visit since I have been on the delegation unless they were from our district. WISCONSIN) Given the scheduling challenges and time tight time restrictions, we do not invite candidates to our pre-caucus meeting.
10	No
11	Yes.
12	Yes
13	Only during the onsite meeting of the house.
14	No Response
15	Yes.
16	Yes
17	Yes.

6A. If so, how many times per year do you invite the candidates to meet with the caucus?

DISTRICT	RESPONSE
1	Once
2	Once/year.
3	Once
4	At the Pre-annual session and the HOD session Caucuses
5	(GEORGIA) Once 5 <sup>th</sup> District: Once
6	Once
7	1 time at the ADA Annual Session
8	2nd caucus then onsite at ADA meeting.
9	(MICHIGAN) 2-our pre-caucus and on-site caucus. WISCONSIN) We invite all candidates to meet with our delegation during our on-site caucus during the ADA Annual Session.
10	N/A
11	Once at our central location meeting and again at the ADA HOD.
12	Once
13	One – at the house itself.
14	Once.
15	During our annual state meeting – TDA Meeting – ADA Candidates Forum During our first caucus in Grapevine
16	Two times
17	Once at FDC June On site caucus at ADA

6B. If so, how long a period of time does your caucus spend with each candidate?

DISTRICT	RESPONSE
1	One day
2	Usually one to two days.
3	15 minutes. There is a social period provided.
4	It depends. Do you mean just formal or casual in a social setting? Formally, three questions and after a 3-4 minute talk and a one minute wrap-up
5	(GEORGIA) Approximately 20-30 minutes formally plus other social opportunities. 5 <sup>th</sup> District: Same
6	30 mins and social events
7	15 minutes
8	2nd caucus is 15 minutes each with 3-4 following questions from delegation. Onsite is 3-4 questions maybe 10 minutes each.
9	(MICHIGAN) On-site at ADA 15-30 minutes. WISCONSIN) Depending on the number of candidates, we try to allocate 15 minutes for each.
10	N/A
11	30 minutes for formal presentation and question/answer session at central location, followed by a more casual evening dinner allowing time to get acquainted with the candidates. 15 minutes for presentation and question/answer session at ADA HOD.
12	Social for 1 day then formal meet/question the next day
13	15-20 minutes
14	We hold a reception, dinners and candidates speak at the caucus.
15	Typically, the 15th District Delegation gives all candidates 20 minutes consisting of a 5 minute introduction, 10 minutes for questions, and a 5 minute closing statement.
16	Usually the evening social event the night before followed by a formal address the following day.
17	15-20 min depending on # of candidates

6C. If so, are the candidates invited to attend any social events and have personal interaction with the members of your delegation?

DISTRICT	RESPONSE
1	Yes but not with all members.
2	Yes. They have attended our welcoming ceremony as well as our golf tournament. They also give a speech and answer questions to our House of Delegates.
3	Yes.
4	Sometimes
5	(GEORGIA) Yes. 5 <sup>th</sup> District: Yes
6	No
7	Yes
8	Dinner with ISDS officers prior to 2nd caucus.
9	(MICHIGAN) No response. WISCONSIN) We have not invited candidates to any of our Ninth District social events.
10	N/A
11	See above.
12	Yes they are invited to all social activities ,golf ,dinner etc.
13	No.
14	Yes. We have a reception and invite the candidates to dinner with the delegates. Each candidate has dinner with a small group of delegates and alternates-it is not a group dinner.
15	Candidates are invited to a leadership dinner during the TDA Meeting and to a special guest dinner during the first caucus.
16	Yes
17	Yes.

7. Are there any other district or state events that candidates could be invited where the majority of the members of your ADA delegation would be in attendance?

DISTRICT	RESPONSE
1	No
2	No
3	No.
4	Occasionally, some candidates are invited to attend Constituent Board or HOD meetings
5	(GEORGIA) 5th District Caucus is usually Sept or Oct, usually after the 2nd set of resolutions are available (2019 we are caucusing in August due to annual meeting of ADA being in September) 5 <sup>th</sup> District: Same
6	No
7	.Not at this time.
8	No
9	(MICHIGAN) No. WISCONSIN) No
10	No
11	No, since our district covers such a wide area over 5 states.
12	Always invited to our states annual meetings as well
13	No. All members of the ADA board have a standing invitation to our annual trade shows/CE conference, but there are no meetings of delegates to which a candidate would be invited.
14	None
15	No.
16	No
17	No.

7A. If so, please identify those events and the dates that they are held.

DISTRICT	RESPONSE
1	N/A
2	N/A
3	N/A
4	Not on a regular schedule
5	(GEORGIA) See above.
6	N/A
7	N/A
8	N/A
9	(MICHIGAN) N/A WISCONSIN) N/A
10	N/A
11	N/A
12	Can only speak for OK but it is in April
13	N/A
14	N/A
15	N/A
16	N/A
17	N/A

8. If your caucus has stopped inviting candidates for ADA President-elect to any of your caucus events or meetings to present their platforms and answer questions (or never issued such invitations), briefly explain why those invitations ceased being issued (or were never issued).

DISTRICT	RESPONSE
1	At times if we do not hold the Boston meeting then at my discretion I have not invited the candidates due to the fact that Nashua is too close to the ADA meeting.
2	I can't answer that question because we usually do invite all of the candidates to our state annual meeting.
3	PDA does not have a HOD. Candidates previously had been invited to the PDA HOD annual meeting
4	They are usually invited. Sometimes they have a scheduling conflict and cannot come, or maybe if one candidate, no invite.
5	(GEORGIA) N/A 5 <sup>th</sup> District: N/A
6	N/A
7	In the past, ADA president-elect candidates were invited to either the IDA Annual Session or ODA Annual Session to meet with both the IDA and ODA delegation to the ADA House of Delegates, which is the 7th District delegation. The IDA's Annual Session is in the spring and the ODA's Annual Session is in September and in close timing to the ADA Annual Session. The 7th District caucus felt that to make the most efficient use of their time, they should review ADA resolutions and meet with candidates simultaneously at a caucus meeting held before the ADA Annual Session. But since the IDA Annual Session is held when no ADA resolutions are distributed (in May/June), it was too early of a time for the caucus delegation to get together to review resolutions, and only meeting with the ADA candidates didn't seem to be the most efficient use of their time. The ODA Annual Session is in close timing proximity to the ADA Annual Session and ADA resolutions are generally available to be reviewed then, but the ODA Annual Session didn't seem to be efficient to invite the candidates to either since the caucus would be meeting with ADA candidates onsite at the ADA Annual Session in a matter of weeks.
8	N/A
9	(MICHIGAN) N/A WISCONSIN) It was too difficult to schedule the visits and allocate the necessary time.
10	We have felt that travel expense and time constraints out weighed the benefits.
11	N/A
12	They are always invited
13	We stopped holding in-person meetings of the caucus/delegation because the timing was such that the majority of resolutions were not available until later than the scheduled meeting date; so we transitioned the preparation strategy to be more flexible. The transition meant that there was no longer an opportunity for such a visit.
14	N/A
15	N/A
16	We believe it is essential to invite candidates to our caucus events and meetings and would not consider not issuing invitations
17	N/A

9. Does your district currently have the ability to utilize videoconferencing to discuss information related to the ADA annual meeting or dental issues that occur throughout the year within its council and committee structure?

DISTRICT	RESPONSE
1	Yes
2	Yes
3	Yes.
4	We have not done that
5	(GEORGIA) Would require District monies and organization 5 <sup>th</sup> District: Same
6	Not to my knowledge, but I am sure it is possible
7	We do not currently use videoconferencing for district caucus meetings.
8	District delegation does not.
9	(MICHIGAN) Yes, Zoom. Zoom also has the ability to record a forum between candidates and post them online for HOD members to access at any time. We use this ability at the Michigan HOD elections and it has received positive reviews from House members. WISCONSIN) Other than the individual reference committees using video conferencing, our delegation has not used this technology.
10	Yes, but it has not been used.
11	We have utilized the ZOOM videoconferencing format in the past for planning purposes, and I assume that could be expanded to include all of the delegates and alternates, but it may be a bit overwhelming with so many people on the call.
12	Possible but has never been used
13	Our pre-house delegation work is exclusively through conference calls (or video-conferencing).
14	No. Although individual states have the capacity to do videoconferencing.
15	Yes.
16	Yes, but generally conventional telephone conference calls are used instead.
17	Somewhat makeshift at this time but basically Yes

10. In regard to using new technologies to substitute or enhance the ability of candidates for elected office to interact with the members of your ADA delegation, would you provide ideas for the task force to consider?

DISTRICT	RESPONSE
1	In addition to the ones aforementioned in your introductions I would consider a few centrally located, live stream, moderated town hall meetings which could allow the savings of funds by providing less travel for the candidates while still allowing the a type personal contact with delegates watching or attending.
2	Video conferencing may be helpful in certain situations but in my opinion, it would not be nearly as effective as the in-person visits to our annual meetings.
3	A video of each candidate answering the same questions could be distributed to our delegates.
4	Obviously, videoconferencing is a possibility. As you know, candidates can call Delegates, which provides for a private and effective opportunity to interact
5	(GEORGIA) N/A 5 <sup>th</sup> District: N/A
6	No ideas at this time
7	No response
8	No response
9	(MICHIGAN) Zoom Conferencing. WISCONSIN) Our district has considered using video conferencing for our pre-caucus, however we feel in-person meetings are more effective and productive.
10	Informational videos, of short length is a nice way to see and hear from candidates.
11	If the candidates are ever to make a video presentation, the candidates should all be afforded the opportunity to connect with the delegates/alternates via a professional studio that has high quality video and audio, such as the ADA headquarters studio used by the ADA President when he/she addresses the membership.
12	All forms of technology should be used when face to face is not possible but we feel there is great advantage in face to face interaction both formally and socially.
13	We have not surveyed the delegates to identify if they feel additional interaction with candidates would support their selection/decision-making. However, the addition of the videos was positively received in general. There was mention of an interest/inquiry/idea about a single online forum for candidates to present a platform and take questions via online chat/pre-submitted. However, I don't have a strong sense of how many delegates would participate.
14	Candidates may want to consider teleconferencing with individual state's delegations. That may be more personal than as a total caucus.
15	Candidates could have a designated video meeting(s) with the delegation.
16	Video conferencing should be considered an adjunct, not a replacement, for face to face meetings. Not all Districts have caucuses outside the ADA Annual session, but those of us who do appreciate the value of building one on one personal and professional relationships that a separate caucus allows.
17	Video conferencing where delegates could call into a central location to hear and see the candidate. Delegates would not have to travel

11. How important is the ability for members of your ADA delegation to personally interact with the candidates in making a decision on which they believe will best fill the position of ADA President-elect? (Scale of 1-5 with one not being important to 5 being very important)

DISTRICT	RESPONSE
1	5 for some 2 for others: I have seen in my tenure 2 groups form within our caucus. Those that still desire the visit and those that feel it could be decided at the ADA saving much money.
2	5 Very important
3	5
4	5, One to one is one of the best ways to interact
5	(GEORGIA) 5 5 <sup>th</sup> District: 5
6	5
7	5 - The Seventh District delegation likes the interaction with the ADA candidates at the ADA Annual Session in the district meetings in order to assess candidates.
8	4
9	(MICHIGAN) I think most of the delegation is at a disadvantage unless they have had personal interactions with the candidates. Since we don't meet them prior to the ADA meeting, we ask anyone that has worked with a candidate to give their opinion. 3. (WISCONSIN) 3 - It is important. We feel that the interaction we have on-site during the ADA Annual Session is adequate.
10	1
11	I would venture to assume it would be a 4, if not 5. The personal contact in a casual atmosphere has been time well spent in past years. A much needed personal touch in this technological age of less face to face interaction.
12	5 see above answer for detail
13	3: The ability to be in the same room with candidates onsite and ask questions has been important (something off the house floor), but our delegation as a whole did not find the in-state visits to be useful. They may be open to a smaller candidate forum event onsite in place of caucus visits (of audience sizes smaller than the house but larger than a single caucus). This is partially speculative.
14	5
15	5 (Very Important)
16	5
17	5

12. Are the caucus meeting(s) or event(s) to which ADA President-elect candidates are invited located near major metropolitan airports?

DISTRICT	RESPONSE
1	Yes
2	It depends on your definition of near but the vast majority of the time – Yes.
3	Harrisburg International
4	Yes, Philadelphia airport is about a half hour away
5	(GEORGIA) Yes 5 <sup>th</sup> District: Yes
6	Usually except when in WV (The Greenbrier)
7	N/A
8	Bloomington IL is not major but has direct flights to many hubs such as Chicago, Dallas, Atlanta, Denver.
9	(MICHIGAN) Yes, Detroit is about 1 hour away and we also have Lansing international airport about 15-20 min away, Grand Rapids and Flint airports are also an hour away. (WISCONSIN) Not really. Our pre-caucus meeting takes place at the Michigan Dental Association Headquarters in Okemos. This is a suburb of Lansing. Although Lansing is the state capitol, the airport does not offer many flights. In fact, because flights in/out of Lansing are a challenge, the Wisconsin delegation travels 5 ½ hours each way to Okemos on a motor coach.
10	N/A
11	Yes.
12	Very close
13	No response
14	Usually they are.
15	Yes.
16	Caucuses rotate between our states. The meeting site is never a long distance from an airport.
17	Yes.

12A. If not, would your caucus be willing to consider relocating these events to increase the efficiency of the candidates' travel and potentially lower the expense of the candidates' attending those events?

DISTRICT	RESPONSE
1	N/A
2	It depends on the circumstances but it may be considered.
3	Harrisburg is centrally located in our state.
4	This is very convenient for the caucus and not difficult for the candidates
5	(GEORGIA) N/A 5 <sup>th</sup> District: N/A
6	Yes
7	N/A
8	No because our state is 550 miles long and a eight hour drive from one end to the other.
9	(MICHIGAN) No response. WISCONSIN) Meeting at the MDA office is much more economical than a hotel. While moving our pre-caucus to an airport hotel could save the candidates money, it would dramatically increase the cost of our meeting.
10	N/A
11	Yes.
12	Yes but it could not be any closer it is literally right next to DFW airport
13	No response
14	Yes.
15	N/A
16	N/A
17	Yes.

13. Would your caucus consider collaborating with other caucuses in the planning of caucus events or meetings to which ADA President-elect candidates are invited so that:

(i) All caucuses who are interested in extending invitations to candidates have the opportunity to do so without creating scheduling conflicts with other caucuses or with major ADA events (such as Board of Trustee meetings)?

(ii) Visits to caucus events or meetings by the candidates can be organized to maximize travel efficiency and to minimize expense?

DISTRICT	RESPONSE
1	Yes I believe so.
2	I think we would discuss the idea.
3	Yes. What percentage of caucus attendance is acceptable?
4	These could be quite challenging, but may be a worthy endeavor
5	(GEORGIA) No 5 <sup>th</sup> District: No
6	Yes. The 6th would be considered anything to stream line the process
7	N/A
8	No
9	(MICHIGAN) Yes for in-person, but our caucus are set up at least a year in advance. This could take a few years to be implemented. IF using Zoom we could implement that this year very easily. WISCONSIN) While the concept sounds good, it would be very difficult to coordinate between Districts. It is already a challenge finding dates that do not conflict with our respective state association activities. In addition, the timing of District pre-caucuses can vary dramatically.
10	Yes.
11	Yes.
12	Yes we already hold ours with Texas (15th) and do not conflict with board activities
13	No response
14	Definitely! As a former campaign chair, it was impossible to coordinate travel. It would be helpful to know in advance what events the states/caucuses would welcome the candidates (a master schedule).
15	Yes.
16	Yes
17	Having been part of the 5th awhile back, I think the 17th would be very reluctant to have joint meetings. We tried when the 17th was first formed and they did not go well.

14. Considering the question of the financing of the cost of a campaign for ADA President-elect by a candidate from your Trustee District, please select the statement from the following list that best describes the District's involvement in financing the campaign:

14A. None. No donations to a candidate's campaign from the District or the constituent or component societies within the District are allowed.

14B. Voluntary. Donations to a candidate's campaign from the District and constituent and component societies within the District are allowed on a voluntary basis.

14C. The District and the constituent and component societies within the District completely fund the candidate's campaign.

DISTRICT	RESPONSE
1	14C.
2	14A: N/A; 14B: Voluntary donations to the candidate from the districts [components].; 14C: No – some members personally donate to the campaign.
3	No response
4	14B: None of these are accurate. This is the closest, but there are also personal voluntary donations from individual dentists
5	(GEORGIA) 14B 5 <sup>th</sup> District: 14B
6	14B Completely voluntary
7	14B: Yes
8	No response
9	(MICHIGAN) 14B: Yes, we solicit donations at the caucus and envelopes are handed out to encourage donations by the chairs. Component societies may make donations as well. 14C: Voluntary WISCONSIN) 14A: Wisconsin Dental Association policy prohibits using state money to fund any officer campaigns. Our component societies have more flexibility and have made contributions to candidates from their respective treasuries. 14B: Any campaign contributions must come from voluntary individual members. 14C: WDA does not allow its treasury to fund election campaigns. Some of our components have financially supported candidates.
10	14B
11	14B: This best describes our District's involvement. Our District does not directly contribute to the campaign, rather, voluntary campaign contributions are solicited from member dentists, dental study clubs, constituent and component societies within each state.
12	No response
13	14C: The state funds the total cost of the campaign.
14	14.B: Yes
15	14B: Voluntary
16	14A: None. No donations to a candidate's campaign from the District or the constituent or component societies within the District are allowed. 14B: We allow voluntary contributions.
17	14B Individuals can also contribute

15. If the District (or constituent or component societies within the District) contributes to the campaign of a candidate from within your District, please briefly describe how the amount of the contribution is set.

DISTRICT	RESPONSE
1	There is a formal vote taken and if the candidate is supported then the district fully funds the candidate by dividing the cost per delegate.
2	It is completely voluntary and decided by each district [component] individually.
3	We have a finite amount for the candidate to use. Previous candidates raised campaign funds however which decreased the amount of District funds that were used.
4	No response
5	(GEORGIA) Member discussion and vote. 5 <sup>th</sup> District: Same.
6	No response
7	In the past, each state within the district has donated funds to a candidate's campaign. But typically the home state of the candidate gives a larger percentage of the donated funds to the campaign. There are no set parameters on how much should be given by the constituent or component societies to a campaign, it's discretionary.
8	A set amount is available to members from the constituent that have been endorsed by the constituent for Pres-Elect, Speaker or 2nd VP. It does not fund the current campaign.
9	(MICHIGAN) Voluntary and it is not specified the amount. (WISCONSIN) The amount is completely up to each component.
10	No Response
11	It is completely voluntary and up to the constituent or component societies to set the contribution amount.
12	Our district has fund to which each state contributes but it is a small amount of the total cost that the candidate raises through individual donations (states amount is voted on by the district)
13	We have a designated fund which is replenished once used through operating reserves, of an amount set by prior board action. Use of the funds requires board approval.
14	Each state is assessed on a formula based on the number of members in that state.
15	Voluntary – No amount specified.
16	Delegates and alternate delegates donate a portion of reimbursed expenses to a "war chest" which is used whenever a candidate steps forward to run for ADA President. Our reserve is capped at \$15,000.
17	The amount varies depending on the current budget and is determined by the Finance Committee. The amount is determined independently from the delegation

### APPENDIX 3 - ELECTION COMMISSION REPORT

Companies	Base Price	Inbound Call	Screener cost	Moderator Cost	Video	Screener
<a href="#">telephonetownhallmeeting</a>	12,500 minutes \$1,500 outbound	\$0.10/minute min inbound.			\$100	Types subject/question into dashboard. Speaker or helper can choose which call to take.
<a href="#">thecontactgroupusa</a>	750 minutes \$2,850 outbound 12,000 minutes \$8,450 outbound	\$0.15/minute inbound	\$150	\$0	\$750	
<a href="#">Stones' Phones</a>	12,500 minutes \$2,050 outbound	\$0.10/minute inbound	Recommend ADA person or \$50	Recommend ADA person or \$250	N/A	
<a href="#">Zoom</a>	Pro - 500 participants \$65/month  Business (Minimum of 10 hosts) 500 participants \$70/month  Moderated or Production Event Support can use either plan.	0	not available	<a href="#">Production Event Support - \$600</a>  <a href="#">Moderated Event Support - \$800</a>	Included	not available
ReadyTalk	Voice over IP -\$0.026  United States Toll (area code 303 typically) - \$0.027  United States dial-out, dial to you - \$0.027  United States toll-free - \$0.029	0	not available	\$150 - .5 hour support during call; .5 hour event planning meeting.  Operator assisted upcharge, for toll-free users, per user -\$0.15  Operator assisted upcharge, for toll, dial out, dial back, per user - \$0.10	No	not available

## APPENDIX 3 - ELECTION COMMISSION REPORT

### ReadyTalk and Zoom pricing models

sample meeting scenarios	ReadyTalk webinar with event support					Zoom webinar with event support				
	number of remote participants					number of remote participants				
	10	50	100	250	500	10	50	100	250	500
6 joint events, 120 minutes each, over 3 months	\$1,109	\$1,944	\$2,988	\$6,120	\$11,340	\$3,665	\$3,665	\$3,665	\$3,665	\$3,665
1 individual event, 90 minutes, one month	\$176	\$281	\$411	\$803	\$1,455	\$665	\$665	\$665	\$665	\$665
6 individual events, 3 candidates, 90 minutes, one month	\$1,057	\$1,683	\$2,466	\$4,815	N/A	\$3,795	\$3,795	\$3,795	\$3,795	N/A
12 individual events, 3 candidates, 90 minutes each, over 3 months	\$2,113	\$3,366	\$4,932	\$9,630	N/A	\$6,195	\$6,195	\$6,195	\$6,195	N/A
27 individual events, 3 candidates, 90 minutes each, over 3 months	\$4,755	\$7,574	\$11,097	N/A	N/A	\$15,195	\$15,195	\$15,195	N/A	N/A
51 individual events, 3 candidates, 90 minutes each, over 3 months	\$8,981	\$14,306	N/A	N/A	N/A	\$30,795	\$30,795	N/A	N/A	N/A

#### Notes on sample meeting configurations:

We priced out several different use case scenarios for ReadyTalk and Zoom services

The first assumes that all events are group events, so only one Zoom account is needed

The remaining scenarios assume that each event is held by an individual candidate, so multiple Zoom accounts are needed

We put "N/A" for meeting scenarios that seemed unlikely

Readytalk prices scale evenly, since pricing is based on per minutes of use and event assist is relatively cheap per meeting (\$150)

Zoom can get expensive for higher event counts because each event assist is fairly expensive (\$600)

Zoom pricing does not change based on number of remote participants because you get up to 500 participants per month for \$65

Zoom monthly pricing could be reduced somewhat if we know we'll not have more than 100 remote participants

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## New Business

**NEW BUSINESS—MAJORITY VOTE REQUIRED FOR CONSIDERATION**Resolution No. 92 NewReport: Election Commission Report Date Submitted: Sept. 2019Submitted By: Margaret Gingrich, 9th Trustee DistrictReference Committee: N/ATotal Net Financial Implication: None Net Dues Impact: \_\_\_\_\_

Amount One-time \_\_\_\_\_ Amount On-going \_\_\_\_\_

ADA Strategic Plan Objective: Organizational Capacity-Obj. 6: Role and responsibility of the tripartite clearly defined and agreed upon

How does this resolution increase member value: See Background

**ELECTION COMMISSION RULES AMENDMENT**

**Background:** In response to the Election Commission Report, (Worksheet:5123) and the footnote, the Ninth District recommends a resolution to immediately implement the ability for candidates to schedule town hall events to include telephonic (phone, text, or digital media) communications with each delegate and alternate delegate and/or district caucuses for the purpose of campaigning.

The Ninth District is requesting clarification of the Election Commission Rules Governing the Conduct of Campaigns for All ADA Elective Officers Appendix 1, Page 50, Section 22 with regard to the term "telephonic communication." The Ninth District is suggesting that the term telephonic communication include phone call or text. We are asking this to be defined because current trends show that dentists communicate with their patients via phone and text and newer delegation members are more likely to respond to a text versus a phone call or email.

**Resolution**

**92. Resolved**, that *The Election Commission Rules Governing the Conduct of Campaigns for All ADA Elective Officers* be amended as follows: (Additions underscoring, ~~deletions stricken~~):

Appendix 1, Section 22 related to Campaign Literature and Communications to Delegate and Alternate Delegates

22. Each campaign is permitted to individually initiate a telephonic (phone call or text) communication with each delegate and alternate delegate a single time for the purpose of campaigning, electioneering and soliciting votes following the receipt from the ADA of the list of certified delegate and alternate delegate contact information.

and be it further

**Resolved**, that Section 24 be amended:

Candidates may each schedule ~~up to three (3)~~ up to three (3) telephone or video conferencing forums or town hall events during the campaign. A candidate desiring to hold ~~up to three (3)~~ up to three (3) telephone or video conferencing town hall events shall communicate to the ADA the date of each event and the times at which each such event shall commence and end, together with the instructions and contact information necessary for participants to email and/or call with the questions they would

**NEW BUSINESS—MAJORITY VOTE REQUIRED FOR CONSIDERATION**

1       like asked during the telephonic town hall. The ADA will announce the telephone or video  
2       conferencing town hall information to delegates and alternate delegates via ADA Connect and  
3       provide the information to the Election Commission members and staff. Candidates may also  
4       publicize the telephonic town halls they sponsor on any closed-group campaign Facebook page  
5       that they maintain.

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